

THE STATE AND MEDICAL CARE IN BRITAIN:
POLITICAL PROCESSES AND THE STRUCTURING
OF THE NATIONAL HEALTH SERVICE

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Abstract

The creation of the National Health Service is treated, analytically and historically, as a planning process involving major changes in the social organisation of health as a part of the larger set of social and economic reconstruction policies undertaken by the wartime Coalition and postwar Labour governments. Definitions of 'health' are considered as relative both to social expectations and ideology, and to theoretical models of the organisation of health services. These models are identified with certain socio-political agents or interests in the providing and consuming of health services: professional groups, public and private authorities, non-professional workers, and the public. The models of the health service advocates and of the medical profession are considered as reference points.

A framework is presented for the analysis of the representation of these interests, by the state, in the planning and operation of the NHS, and as beneficiaries of its services. Through a detailed historical consideration of internal health service planning documents of the major interests, including the medical profession, the health service advocates representing the Labour party and trade unions, and recently released documents of the Ministry of Health and the Coalition and Labour Cabinets, the interaction of the interests with the two governments and with each other is traced, and the reconciliation by the state of the health service models proposed by them is analysed.

It is argued that the changes wrought in the social organisation of health in Britain can be described according to certain principles of the organisation of pre- and post-NHS health services: principles of public access, structure of services, structure of administrative control and structure of planning representation. The major interests were represented differentially by the state with respect to each of these criteria; similarities and differences between the approaches of the two governments to the representation of interests are examined, and it is concluded that, although the health service advocates and the public benefited from a free and universal scheme, the public and non-professional health workers enjoyed considerably less representation than the medical profession in the particular services provided by the NHS and in its planning and administration.

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This dissertation is the result of the author's own work and includes nothing which is the outcome of work done in collaboration.

List of Abbreviations

BHA	-- British Hospitals Association
BMA	-- British Medical Association
COHSE	-- Confederation of Health Service Employees
DHSS	-- Department of Health and Social Security
GMC	-- General Medical Council
GP	-- General Practitioner
KEHF	-- King Edward's Hospital Fund for London
MP	-- Member of Parliament
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NALGO	-- National and Local Government Officers' Association
NCL	-- National Council of Labour (of the Labour Party, TUC and Co-operative Congress)
NEC	-- National Executive Committee (of the Labour Party)
NHS	-- National Health Service
NUPE	-- National Union of Public Employees
PEP	-- Political and Economic Planning
PLP	-- Parliamentary Labour Party
PRO	-- Public Record Office
SMA	-- Socialist Medical Association
TUC	-- Trades Union Congress

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CHAPTER 1

INTRODUCTION:

HISTORICAL AND THEORETICAL APPROACHES TO THE

STUDY OF THE NATIONAL HEALTH SERVICE

Themes of the Study

The National Health Service is rightly seen as a most significant element of British postwar social policy, a landmark in the transformation of social and economic relations accomplished under the aegis of the state. It bears important structural similarities and differences to schemes for the provision of medical care undertaken by several western nations as part of their planning during the Second World War for postwar construction. It bears equally important similarities and differences to alternative model schemes advocated in Britain in the same period by representatives of the organised medical profession and, on the other hand, by representatives of the socialist and labour movements.

This study is concerned, historically and theoretically, with the formation of state policy leading to the implementation of the National Health Service (NHS) in Britain in 1948. The processes involved in this policy formation, it is suggested, are essentially political. They may be analysed through a variety of approaches, from the empirical and historical to the abstract and theoretical, from particular debates and negotiations over health policy to the more general imperatives, based

on the nature of a mid-twentieth century capitalist economy and society, toward state intervention in the creation of major health and social service systems. The concern here is to locate and analyse debates, campaigns and negotiations over the main principles and structures of the NHS within the context of the political dynamics of an advanced capitalist society, in particular within the context of the wartime reconstruction of economic and social relations in Britain.

The analysis can be seen as a contribution to the ongoing discussion of the welfare state. Most of the main historical accounts of the genesis of the NHS focus upon the conflict between the British Medical Association (BMA) and the two governments. Both the theoretical and the historical intent here is to shed some light upon what might be thought of as the other side: the advocates of a state health service who took their position on behalf of the public as consumers of health services and on behalf of the large number of non-professional workers in the health services. These groups held, as part of their overall political or ideological position, that only a state-provided, fully comprehensive and co-ordinated health service, open to all without financial or other eligibility barriers would be an adequate replacement of the chaotic and class-biased system then in existence. Democratic organisation, the rights of health workers and the addressing of preventive and occupational health issues were especially emphasised. This position was taken as part of the reform programme of the labour movement, and by socialists as part of the programme for the transition to a socialist Britain.

This position has not, as yet, received a great deal of attention in the literature on the history of the NHS; nor has the relationship of

the health service advocacy campaign to the government policy making process, and to its outcome, the NHS Act and its amendments.

It is hoped the study will make a double contribution to the welfare state discussion, first through its specific historical approach, which examines the policy making processes in considerably more detail than earlier studies of the formation of the NHS, and second, through bringing this new set of historical data to bear upon an analytical approach which itself is of much recent interest, the political sociology of the British welfare state.

The NHS was created as part of the series of social and economic interventions by the state -- in housing, income security, employment, education, to name but a few areas -- popularly termed the 'welfare state'. These new interventions, provisions and institutions, referred to at the time as 'reconstruction', represented a process of state economic and social planning, begun early in World War II, designed both to facilitate the execution of the war, and the return to stable peacetime conditions. Security and reconstruction were at the time interpreted in the broadest economic and social senses; it was widely seen, among business, government and labour circles, although not unanimously, that for the war to be waged effectively, especially on the home front, for Britain to return to peacetime productivity, prosperity and political stability, and, given the fundamentally private nature of the economy which was both the cause of much insecurity and at the same time the foundation of Britain as an industrial nation, that the state must intervene to reduce or eliminate intolerable pre-war insecurity -- the vicious cycle of unemployment, poverty, poor health and poor education so dramatically pointed out by Sir William Beveridge in his

landmark Report of 1942. (1)

The planning, legislating, implementing, executive and regulating functions of reconstruction, begun early in the Second World War, involved not just the two governments in charge, the Coalition government of Sir Winston Churchill, and the Labour government of Clement Atlee. Rather it involved the state in the largest sense: the complex of institutions, legislative, executive, and judicial; central government Ministries and permanent civil servants; local government and its executive agencies. (2) These were the branches of the state in charge of formulating plans, carrying out detailed consultations and negotiations with parties affected, drawing up and administering legislation. Cabinet and Parliament were, of course, in both a formal and substantive sense, in charge of final legislative policy decisions. Here party platforms, social philosophies and ideologies, and aggregations of interest groups identified with each party, had their influence, but not an exclusive influence. In a very important sense the Ministries, particularly the senior advisers to the Ministers, had a determining effect on the initial appearance of policy and legislation, if not upon the final, formal decisions. Equally, since local government was involved in administering much central government policy, especially in the health and social services, its role too must be considered a part of the role of the state.

The creation of the National Health Service, like many of the reconstruction policies, involved this entire complex of state institutions, which, for purposes of brevity we shall denote the state. The state is thus distinguished from government, by which we mean the Prime Minister and Cabinet constituted upon the majority party or

parties in Parliament. Government in the final analysis is responsible for policy legislation and ultimately for administration, while the wider institutions of the state are responsible for preparatory planning, administration, and liaison with forces outside the state, in 'civil society'. Thus we are concerned here with the role of party government in the wider context of state involvement in reconstruction policy making, of which the NHS was a part.

We are concerned, especially, with the field of interests in society within which the state, and governments, must operate. The British state, during World War II as now, existed in an economy and society based upon private property and private ownership, with traditional, elite control of many non-state institutions (including, for example, the medical profession), and with a working class well organised but only beginning, in World War II, to be represented in policy making. This representation was through the mechanism of tripartism, through which the government, employers, and labour (the latter largely through the efforts of the Labour Party Ministers in the Coalition government) consulted on major economic and social policy matters, with the object of minimising disruptive conflicts. Indeed, one of the premises of this study is that the reconstruction process represented a massive intervention by the state to reorganise inherently dysfunctional aspects of an otherwise laissez-faire economy, to create a network of institutions for individual security and opportunity, in the interests of the long-term stability and profitability of the private economy. Inasmuch as this process represented an intervention by the state in the laissez-faire economic relationship between capital and labour, it can be seen as an at least partial reorganisation of the

social relations of capitalism.

The NHS itself was planned through a complex process which involved reconstruction policy initiatives from within and outside the Ministry of Health, political party influence on Cabinet and Parliamentary decisions, and consultation by the Ministry with, or its taking account of the views of, a variety of interests directly and indirectly concerned with the provision or reorganisation of medical services. These included consumer, labour, professional, hospital and local authority interests among others.

The state had available in its planning endeavours alternative models of a national health service identified with or advocated by a range of conflicting interests in the organisation, provision and utilisation of medical services. These models might be placed on a continuum and identified with alliances of the major interests. On one end might be placed the modified but still restrictive National Health Insurance model of the insurance companies, the medical profession and the voluntary hospitals; on the other, the plan for a 'socialist' comprehensive, state-owned, fully salaried scheme advocated by the Labour Party, the Socialist Medical Association, the Trades Union Congress and others, which we shall refer to as the advocate groups. In the centre of the continuum might be found a model representing a liberal compromise among the major conflicting interests, a free, comprehensive and universal scheme relying on state co-ordination rather than state ownership, with less emphasis on integration, preventive health, and elimination of class biases than that of the advocates and offering more scope for professional autonomy and private practice. This was a model favoured by some Ministry of Health officials, some

members of the medical profession, and would have been accepted by some of the advocates. These, then, in summary description, were the models to be reconciled or adapted by the state in response to the general social and political imperatives toward a health service and to the conflicting interests actively involved in the planning process.

The rival groups and alliances of interests had great significance both as indispensable participants in the provision and management of health services at all levels, and as purveyors of plans and blueprints for reforms, minor or major, to the government of the day and to the public. They thus operated through at least two political channels, direct approaches to and negotiations with government, and indirect pressure, through raising the practical and ideological implications of their blueprints in the arenas of public, trade union, party, and parliamentary politics.

It is thus apparent that the policy models represent not only narrow interests of the affected groups, but alternative models of the role of the state, not only in the provision of medical and allied social services, but in the economy and society. They represent alternative models of both the social definition of health, and of the social organisation of health services.

At the one extreme, the state would have served only a regulatory, co-ordinating and subsidising function, with the institutions of care and insurance being firmly in professional, voluntary, or other private hands, with the exception of the local authority facilities. The private sector would, in effect, have been reinforced, while being subject to increased regulation, and the private-public medical care dichotomy exacerbated. At the other extreme, the state would have been

the owner of all facilities, the direct employer of all personnel, and would have established and co-ordinated a series of old and new health functions, from prevention to rehabilitation, in a one-class, all public service.

It is the argument here that both the features of the NHS, and the processes by which it was planned, legislated and implemented are the result of the state on the one hand taking the initiative in the face of a set of political and economic circumstances requiring fundamentally reorganised, accessible, and effective health services, and on the other hand, responding to the alternative models of a health service, advocated by the major alliances of interests in the provision and use of medical services. In this process the state did not act merely as a neutral arbiter.

Thus it is further argued that there was a complex and differential structural representation of the major interests in state policymaking. This included a differential representation of the interests, and alliances of interests, with respect to each of the two governments concerned, Coalition and Labour. This differential representation, and the priorities of the state to override the particular viewpoints of pressure groups are demonstrated both in the features ultimately included in (and excluded from) the NHS, and in the bargaining and consulting processes between the state and the interests affected, which are documented historically in the following chapters.

The NHS, as planned by the Coalition government, and as revised and enacted, and ultimately amended by the Labour government, did not follow directly the policy of either the Conservative or Labour Parties. Nor did these intermediate and final versions of the NHS correspond directly

to the viewpoints of the interests ostensibly allied with each party, for example the medical profession with the Conservative Party and the health workers' unions and the Trades Union Congress (TUC) with the Labour Party. Features of the plans, and the planning and consulting processes were, indeed, often anomalous when compared with traditional party policies and alliances of interests. For example, the Coalition government accepted the universal and comprehensive scheme advocated by labour and bitterly opposed by the medical profession; the Labour government nationalised all hospitals, but turned down the occupational health service vociferously supported by the labour movement and Party (and the medical profession), and granted concessions to private practice tending toward a two-class system, which were demanded by the medical profession, opposed by the TUC and contrary to Labour's health policy. By both governments the medical profession was given first priority in the procedures of consulting and negotiating, such that, even if it did not win the plan of its choice, it was able to set the terms and conditions of service. Those interests making up the alliance of health service advocate groups on the other hand -- the TUC, the Labour Party, the Socialist Medical Association, among others -- did win the universal scheme of their choice, but not certain important features including full-time salaried medical service, occupational and preventive health, and neighbourhood health centres, which they deemed critical not only to the success of their model, but to its larger purpose of reforming fundamentally the social organisation of health.

It is therefore argued that the creation of the NHS, including these apparent anomalies in policy, may be explained with respect to the policy priorities of the state in the context of its reconstruction

planning, in the constraints of a capitalist economy, and with respect to the particular structural representation of interests in government and state policymaking, all of which formed the basis for the evolution of the NHS plans under the two governments, and the legislation and ultimate amendment of the NHS Act.

It is for reasons of this analysis that methodologically neither a traditional study of pressure group politics, nor a narrowly-conceived Marxist approach, nor a purely historical account of the creation of the NHS is adequate. Pluralism is unable to conceive of the state as other than a neutral arbiter among conflicting pressure groups or interests of potentially equal power, and certainly does not see state policy in relation to dominant institutions, philosophies and practices of capitalist society, and structural blocs of interests such as capital and labour and fractional formations within them. Marxism, until the recent advent of debates on the relative autonomy of the state from the dominant influence (or direction, as 'vulgar' Marxism would have it) of capital, and studies in the political economy of state institutions, had little to offer in the way of subtle analytical tools by which the origin and use of state policies could be explained; Marxist analyses tended toward overly general references to the level of class struggle between capital and labour, and the relative captivity of the state to a monolithically-conceived capital. (3) A purely historical approach, lastly, presents a chronicle of relevant events, but lacks the possibility of a rigorous interpretation of dynamics rooted in social, political and economic structures.

A sociological approach is clearly necessary -- one recognising the political nature of the processes involved and their origins in the

social and economic structures of a capitalist society.

In this study, the approach taken must account for several things. It must first account for the creation of the NHS (among the various institutions created during the process of reconstruction) as a part of the role of the state in reorganising and ameliorating the social and economic conditions prevailing within British capitalism prior to the War. It must secondly account for the initiatives of the state in response to the many fundamental problems of medical practice and its determination of a policy ostensibly in the general interest. Thirdly, it must account for more than just the detailed interactions of pressure groups and the government of the day, but the apparently differential treatment accorded to the various major interests concerned in the creation of the NHS. Lastly, it must account for the resolution of these factors -- the significance of the chosen designs for the NHS, under two governments, in relation to the policy alternatives available, and the differential treatment accorded to interests advocating them, for the state's role in the social reorganisation of medical care, and its larger role in the reorganisation of capitalist social relations.

The study therefore makes use of a methodology drawing on several approaches: an historical approach, using new primary archival data; and the data and analyses of earlier pressure group studies concerning the medical profession and the NHS; but primarily it is a study within the parameters of recent Marxist debates on the political sociology of the welfare state. It may be seen as case study in the policymaking processes of the state, in its task of restructuring the social organisation of medical care, as a part of the larger project of its partial reorganisation of the social relations of British capitalism in

the Second War and after. The chief assumption is the relative independence of the state, under both governments, from the direct interests of either capital or labour in the larger sense, or organised medicine and the labour movement and health service advocates in the case of the NHS. The chief problematic, to recapitulate, is the relationship between features of the NHS, as they were adopted from the alternative health service models, and the representation of the interests concerned in planning, working within, or consuming the services of the NHS.

In the remainder of this chapter, we shall consider four bodies of literature which are relevant to the historical and analytical approaches here. These are: historical and pressure group analyses of the NHS; the literature on the social organisation of health; the welfare state and the political economy of the state; and on the representation of interests in policy making.

Early Studies of the Origins of the NHS

Most of the works on the origins of the NHS which have come to be accepted as authoritative were written relatively early in its existence and were intended to serve the dual purpose of providing general historical or sociological background to the founding of the service, and, equally importantly, to provide informative description and analysis of the performance of the new service in operation.

The two best-known of the historical and descriptive studies are those written by James Stirling Ross in 1952, and by Almont Lindsey in 1962. (4) Several works combine both historical and sociological approaches. Harry Eckstein has written two works, from different

perspectives. THE ENGLISH HEALTH SERVICE begins by analysing the condition and class distribution of medical services, inequalities in access and anomalies of the insurance system, then describes the changes wrought during World War II through the government's organising of the Emergency Medical Service (EMS), which he sees primarily as an act of rationalising and redistribution. He looks at the views of the main political protagonists in the debates over health services in the interwar period: the political left; the voluntary hospitals; and the medical profession, with its several divisions, including the BMA as its most representative association and chief pressure group. He reports in some detail the stormy battles between the Coalition and Labour governments and the medical profession over health service plans from 1942 to 1946, emphasising divisions in the profession's interests and strategies, and the fundamentally rationalising, efficiency-oriented motives of both governments. The government-medical profession relationship is the primary focus of his analysis of the course of planning and implementing the NHS, against a background of structural deficiencies in services exacerbated by two wars and interwar economic depression. (5)

A second work by Eckstein, PRESSURE GROUP POLITICS, (6) is a study of the organisation, tactics and effectiveness of the BMA as a pressure group, cast in the framework of classic pressure group theory. Eckstein here seeks the factors which determine the 'form', the 'intensity and scope', and the 'effectiveness' of the BMA as a pressure group. These in turn are affected by: the pattern of governmental policy, the structure of decision making of both the group and government, and the prevailing attitudes or 'political culture' within which the group

operates. Against this theoretical background, Eckstein provides a great deal of informative detail regarding the structure and strategies of the BMA, and the ways in which its interests are represented in the Ministry of Health. Much of the detail concerns the BMA's role in the planning of the NHS, and its successes and failures in pressing for amendments subsequent to the implementation of the NHS. Eckstein develops several theses regarding the effectiveness of the BMA as a pressure group.

Another pressure group study, by A. J. Willcocks, *THE CREATION OF THE NATIONAL HEALTH SERVICE*, (7) provides a systematic account of the published positions of a wide variety of interested groups on issues relating to the design of the health service, and compares these with the views of the government, at four key points in the planning of the service: (a) the short-lived plan of March 1943 of Ernest Brown, the Coalition government's (Liberal National) Health Minister; (b) the White Paper of February 1944 of his Conservative successor, Henry Willink; (c) revisions to the White Paper discussed confidentially by Willink with major interest groups in March and April 1945; and (d) the National Health Services Bill introduced by Labour Health Minister Aneurin Bevan in March 1946. A variety of groups were considered by Willcocks, divided into three categories for purposes of analysis: those with skills to offer, including the professions; administrative organisations, including the local authorities; and those with property to offer, including the voluntary hospitals. Accordingly, the published positions of a number of associations, from each of these categories, were examined, and related to the government's announced intentions, at the four planning stages, with respect to several major substantive

features of the health service: financing methods and extent of population to be covered; central administration and advisory machinery; and the services themselves, divided into hospitals, general practitioner, local authority, and other services. By means of comparing the groups' views, with the government's plans, at the key points, with respect to the health service features, Willcocks demonstrates the relative 'successes' and 'failures' of the groups in having their views realised, or interests served, in government policy. He concludes that, of the three categories of groups, those with skills to offer, particularly the medical profession, achieved the greatest 'success', measured against the provisions of the NHS Act.

Gordon Forsyth, in *DOCTORS AND STATE MEDICINE*, (8) documents and analyses changes in the functioning of the NHS up to the mid 1960s, in response to the changing distribution of medical need, changing professional pressures, and as the result of recommendations of several official commissions and review bodies. His primary emphasis is on contemporary financial, medical, epidemiological and professional aspects of the NHS. After noting changes in the method and amount of payments to physicians under the service, he sets out a theoretical model of a continuum of medical care, based on the assumed NHS goal of continuity of care from presymptomatic factors in vulnerable groups through general practitioner and specialist care, to convalescence, rehabilitation and readjustment. Forsyth's critical evaluation of the actual performance of the NHS points out weaknesses in all phases of the spectrum, but especially in the sphere of general practice and its links with specialist and rehabilitative care. While one of the chief goals of the NHS (and one of the chief arguments of the health service

advocates) was to integrate and co-ordinate levels of care, the separation of general practice from the hospitals, which became the base of the specialist services, and the subsequent failure after 1948 to implement the reorganising of general practice into neighbourhood health centres which would have been the vehicle for co-ordination of services, meant, in effect, the reinforcement of the isolation of general practice, according to Forsyth.

Two historical accounts of the founding of the NHS are written from a socialist perspective. These are Dr David Stark Murray's WHY A NATIONAL HEALTH SERVICE?, and the portions of Michael Foot's biography of Aneurin Bevan dealing with Bevan's taking over the Ministry of Health in the 1945 Labour landslide, redesigning some major aspects of his predecessor's plans, and piloting the NHS Bill through Parliament and through a period of concerted opposition from the BMA. (9) Dr Murray, one of the founders of the Socialist Medical Association (SMA) and active with his organisation in Labour Party politics, describes the beginnings of the SMA, its development of blueprints and strategies for a 'socialist' state health service, and its political activities within and outside the Labour Party. He notes progress achieved, and failures, with respect to three issues which were the hallmark of the SMA's blueprint: an occupational health service; full-time salaried service for all doctors; and the proposed network of local health centres. Despite the SMA's close political relationship with Aneurin Bevan, their advice to him on these three fundamental issues was not ultimately taken.

Michael Foot's work on Bevan is valuable in several respects. As a political biography, it places Bevan, after he took over in 1945 as

Minister of Health with full responsibilities for housing, in the context of party, government, and interdepartmental politics. Foot refers to the health service plans and the permanent officials Bevan inherited, the sometimes conflicting priority of housing, Bevan's relationship with senior members of Cabinet, and describes in considerable detail Bevan's dealings with the BMA through the difficult years 1945 to 1949. His discussion of Bevan's strategy with respect to the medical profession is useful in comparison with Eckstein's discussion of BMA strategy. Most relevant in the present context, however, is Bevan's attitude toward outside pressure in relation to Parliamentary and Cabinet privilege. Before the NHS Bill was published, his discussions with the BMA were on an entirely non-committal basis; he would not, until the Bill was passed, engage in 'negotiations' committing Parliament, a priori, to concessions. On the other side, Bevan's relations with his socialist colleagues of the backbenches and in the SMA at crucial times followed the same principles as his dealings with the BMA, apart from the fact that the BMA continued to enjoy its traditionally privileged formal access to the Ministry and its officials. For his apparently aloof Ministerial stance, and his traditional arguments for it, he gained some criticism from socialist colleagues, which Foot also documents.

Bevan gives his own opinion of these issues, and his particular philosophy of the welfare state in *IN PLACE OF FEAR*. (10) Both these works by Foot and Bevan are journalistic in style, but Foot portrays particularly well Bevan's sometimes stormy dealings with the BMA, and his astute strategies with respect to Cabinet colleagues, backbenchers, the BMA, and the voluntary hospitals and local authority interests, by

which he was able to design and sustain major changes to his predecessor's White Paper proposals. Neither Foot nor Bevan himself discuss relations between Bevan and his sometimes critical colleagues among the socialist health service advocates.

Thus there exist general histories of the NHS in larger works which address other questions, such as the functioning and later adaptation of the NHS, pressure groups, or the political biography of the Minister who inaugurated it.

Apart from the few early works which treat aspects of the NHS sociologically, two recent works discuss the NHS from a Marxist point of view. Lesley Doyal, in *THE POLITICAL ECONOMY OF HEALTH*, considers the social production of health and illness and of medical care in relation to capitalist industrial, and colonial, economic structures, and the reproduction of the labour force in each case. She concludes that the NHS represented an extremely important social reform in providing, theoretically, equality of access to medical services for the British population, and that, as such, it was an important political gain for the working class in the 'post-war settlement' between capital and labour. She agrees with P. Corrigan who suggests that the political and ideological organisation of the working class was insufficient for it to have a major share in determining the way the NHS was created or subsequently controlled. (11)

Vicente Navarro, in *CLASS STRUGGLE, THE STATE AND MEDICINE*, a survey of state involvement in the health sector in Britain from 1911 to the 1970s in relation to the balance of class forces, draws similar conclusions to those of Doyal. He finds particularly that the Labour government, far from reversing traditional class relationships in the

production of medicine, actually reinforced the hierarchical role of the medical profession in the service, and virtually neglected the labour movement in its management structures, and in the lack of special occupational health services. (12)

The Social Definition and Organisation of Health

It is only relatively recently that sociology has embraced theoretically the study of illness, the health professions and their ideologies, and the structure of health services, with attempts to relate these previously disparate areas of study to characteristics of the surrounding social structure. (13)

Hans Peter Dreitzel argues that medical ideology and the scientific method have tended to individualise and isolate medical problems and solutions, neglecting relationships with social and economic forces. The profit-making basis of capitalist economies, he suggests, has tended to foster ideologically 'instrumentalist' attitudes toward people as workers, or as factors in production, along with giving rise to medical and psychosocial pathologies related to the long hours, competitiveness, stress and environmental hazards of industrial working conditions. From this an 'instrumentalist' concept of health arose, identifying health with capability to work:

Obviously then, there is a functional relation between the internalization of the instrumentalist attitude and the maintenance of a social system based on productivity and profit. In our capitalist societies, health is institutionally defined as the capability to help produce the very surplus the owners of the means of product appropriate.

He notes the significant social class differences in the incidence of physical and psychiatric illnesses and the neglect of the aged,

chronically ill, and disabled in medical services. Making an important distinction, with respect to the origin and the solution of these medical inequities, he points out: "If the incidence of illness is to a large extent a SOCIAL problem, the organization of health is a POLITICAL one." (14)

The relative nature of the definition of health, relative, that is to the structure of the society and economy, is a point made separately by Martin Rossdale and Ronald Frankenberg. Rossdale traces the development of scientific medicine, with its emphasis on the cure of individual pathologies, and its failure, and indeed the failure of modern health services, to tackle the social bases of pathologies, for example the relationship of tobacco production to cigarette smoking to lung cancer, and the relationship of industrial production to chronic bronchitis. Medicine, even socially organised as it is in the welfare state has preserved the patient-doctor relationship as an intimate and isolated one; the doctor's duty is to treat only the individual symptoms of the individual patient. (15)

Frankenberg reviews several sociological approaches to health and health care. He begins with Marx and Shaw on the relation of ill health to early capitalism, then considers the eminent medical historian Henry Sigerist as a link with modern medical sociology. Sigerist was well aware of social and economic factors in illness, and a radical critic of them. His solution, however, was in large measure a medical one. He urged an obligation upon physicians to engage in preventive medicine and health promotion through education, especially for social groups most at risk, and the personal and social rehabilitation of patients. Frankenberg concludes that in advocating this last task, the

readjustment of patients to work and family life rather than the provision of healthy and fulfilling working and living conditions, Sigerist has much in common with functionalism, with professional elitism, and, in the end, with 'intelligent conservatism'. Sigerist was, in his time, a 'radical reformist', in advocating medical solutions, in relative isolation, to essentially social problems. But the social bases of disease, as well as the ideology and the patterns of organisation of medical practice, are, according to Frankenberg and other Marxist analysts, related to fundamental class divisions in capitalist societies. Thus, while Freidson, the American medical sociologist, may criticize the ideology and the dominant power of the medical profession, his solution of greater lay administrative direction and limited patient-power is a liberal one; it too does not address the question of the appropriate organisation of medicine to meet the underlying social and economic causes of disease. (16)

A more precise formulation of the definition of 'health' in relation to its social basis is undertaken by Sander Kelman. He argues that 'health' must be seen in an essentially social, rather than strictly biological way. He suggests two opposing definitions of health, 'experiential' and 'functional': "The former may be defined as freedom from illness, the capacity for human development and self-discovery, and the transcendence of alienating social circumstances," and the latter, after Parsons' definition, "the state of optimum capacity of an individual for the effective performance of the roles and tasks for which he has been socialized." Kelman too links medical ideologies and treatment paradigms, and the organisation of health services with their guiding ideologies, to the social and

economic structure. He develops his argument considerably more fully, however, than do Dreitzel, Rossdale, or Frankenberg. He does this using a materialist approach to the study of health in capitalist societies, linking the prevailing or operational definition of health, the 'functional' definition, with a key economic feature of capitalism, the drive to accumulate capital. According to his thesis, tendencies in medical organisation or ideology toward the maintenance of minimal 'functional' health or work capacity would be in conflict with the more subjective and positive impulses toward 'experiential' health. Economic resources devoted to the latter, to the attainment of higher than merely functional levels of health, would be seen then as wasteful expenditures from the point of view of capital, and as a drain on capital accumulation. What results, in reality, according to Kelman, is a state of 'health' which is "nothing more than the prevailing standoff at a point in time between its functional and experiential aspects, between the tendency for the accumulation process to reduce its subsumed human populations to the status of resources employed for its expansion and the tendency of people to seek their own transcendent (of the accumulation process) fulfillment." (17)

A balance between these two aspects of health is what Kelman suggests is produced by health policy in capitalist societies, due to the conflicting ends of capital accumulation and personal and collective fulfillment. To determine the precise nature of that balance, therefore, one would look to the extent of social resources spent on guarding and improving the general health and wellbeing of the whole population (including the aged and non-working groups) as compared to that spent on health solely as related to productivity, although the two

categories, like the two definitions of health, are in reality not mutually exclusive. They are, rather, models or theoretical definitions, which are indicative of tendencies in the economic and social system and in the social organisation of medicine.

Using these definitions of 'health' and their implications for health policy, we are here interested in the extent to which they apply to the NHS. As we shall see subsequently, these theoretical definitions of Kelman correspond to the opposing philosophical principles and political approaches and the model health services proposed by, for example, the early socialist advocates of a national health service who stressed 'positive health', and on the other side, by the advocates of schemes such as Lloyd George's National Health Insurance of 1911, which was concerned primarily with returning the sick or injured worker as quickly as possible to productivity.

These rival concepts of health resurfaced during the reconstruction planning of the 1940s in the polar positions of the SMA and the BMA. Elements of both were incorporated by the Ministers of Health in their construction of the NHS.

While Kelman, using a Marxist approach, elaborates conceptions of 'health' related to countervailing tendencies within capitalism, linking his definition of 'functional health' in general terms with the tendency toward maximising productivity and capital accumulation, Arthur Schatzkin uses the same paradigm to elaborate the connexion between health and the Marxist category 'labour power', in relation to production and capital accumulation. (18)

'Labour power' is considered in Marxist theory as the productive capacity of an individual to work, purchased in wages from the worker,

by the capitalist, who is able to pay these wages from the sale of the goods produced. A part of the total proceeds goes to the worker as wages, and part is retained as 'surplus', going toward capital accumulation. In the Marxist paradigm, wages going to the worker are minimised (in the interest of maximising accumulation) so that they represent, in theoretical terms, only the 'value of labour power', or the amount necessary for the basic maintenance of the worker and his family -- for the daily subsistence and the generational reproduction of labour, termed the 'reproduction of labour power'. Included in costs necessary to produce labour power are the basics of life, food, shelter, and the like, education to a level sufficient to contribute adequately to production, and health:

Health under capitalism is an integral component of an individual's labor-power or productive capacity. The capitalist's objective interests reside only in the use-value of labor-power, that is, how much value the worker produces. A certain level of physical and mental health is thus necessary to maintain the maximum level of productivity. Below that level of health, the capacity to work falls off, and with it the amount of surplus-value that will be generated. The capitalist is simply not interested in the level of health beyond this, although the worker will be vitally interested from the point of view of quality of life, not of productive capacity. . . . It follows from this conception of health as labor-power that medical care services are designed to maintain the requisite level of health, a kind of labor-power 'repair and maintenance service'.

Analysing health costs as related to capital accumulation, Schatzkin notes:

Since the provision of health is part of maintaining labor-power, it represents to the capitalist part of the wages he must pay out -- whether it is direct wages which buy food to keep the worker healthy or indirect 'social' wages in the form of medical services. Thus, the provision of health, although a necessary part of the overall process of surplus-value generation, represents IN ITSELF a surplus value LOSS for the

capitalist. (19)

There would be assumed in this formulation to be an optimum level of social expenditures on health, from the point of view of capital, whereby an optimum state of health in the labour force is attained, such that production is not unduly impeded due to poor health, nor is the generation of surplus, or accumulation of capital, impeded due to excessive (or 'non-essential') expenditure on the 'social wage'. Thus, a hypothetical balance must be reached, from the point of view of capital, in spending on health, which is similar in essence to that referred to by Kelman, the balance between society's recognition of and provision for 'functional' as compared to 'experiential' health.

Thus Kelman stresses the definitional aspect of health in the theoretical context of a Marxist paradigm, and Schatzkin notes the economic relationship among spending on health, the reproduction of labour power and capital accumulation.

Lesley Doyal, also elaborating a Marxist analysis of health care, discusses, in addition to the points noted above, its ideological significance, and its role in the reproduction of the social relations of capitalism:

If capitalist production is to continue, there must be a renewal of its 'general conditions' as well as a renewal of the means of production. Mechanisms must therefore exist for capitalist societies to reproduce themselves. Two things in particular need to be reproduced -- the productive forces and the existing relations of production. That is, there is a need to renew both the 'inputs' of production, and also the sets of beliefs and relationships that hold society together. Included in the forces of production are its material conditions (raw materials, buildings, machines, etc.) and also the labour power of workers. . . . However it is important not just that the labour force should be physically regenerated, but that it continues to work within a set of economic and social relationships. . . . [M]edical care is a highly significant factor in the reproduction

of both the forces and the relations of production. (20)

The effects of the system of provision of medical care on social relationships and ideology, in Doyal's analysis, are at least threefold. First, modern high technology medicine aids in establishing, by reflection from its assumed record of spectacular scientific cures and techniques upon society's general commitment to science and efficiency, the overall legitimising of the existing social system. Second, the bureaucratic, hierarchical and authoritarian social relations within the structure and practices of medical care, both among staff, and between doctors and patients, reinforces existing hierarchical patterns of socialisation and social control. Third, "it is precisely because health, and therefore medical care, are so vital to every individual that the provision of medical care often comes to represent the benevolent face of an otherwise unequal and divided society." (21) Socially, therefore, medical care represents simultaneously the reproduction of professional elitism and hierarchy, lack of autonomy and dependence, but also, because of the vulnerability of the sick, the reinforcement of an apparent benevolence on the part of the providers of care, including the professions and the state. In these ways, medical care contributes to patterns of socialisation in the wider society, and to the reproduction of social relations.

This, of course, begs the question of the particular nature of the health care system, or, to use Doyal's term, the nature of the "mode of production of health care." Analysing the social organisation of a health care system in these terms involves examining the structuring of a given medical care system in relation to the forces and interests which formed it and influenced its evolution, the role of the state in

creating and maintaining or merely regulating the means of provision of health care, and some attempt at determining the social functions -- the effects and effectiveness -- of that system.

The first and most outstanding fact about the NHS, in this context, is that, in the broadest sense, it is a universal, free, state system of health care provision. The three branches of its tripartite division, general practitioner, hospital and specialist, and local authority services, are all ultimately united under the (now) Department of Health and Social Security (DHSS). In the change in 1948 from National Health Insurance to the NHS, private ownership of hospitals was ended by the nationalisation of virtually all hospitals, practitioners became contracting agents of the service, and, apart from the small but important remaining sector of private practice, private insurance was ended. The state thus figures most importantly in the creation and operation of the NHS and in the vast social reorganisation of the health system which this involved.

Approaches to the Study of the Welfare State

Since the Second World War a wide range of government provisions for education, housing, social security and the like have come to be summarised in the rather amorphous popular term 'welfare state'. The key here is the reference to the state, for it is the substantial intervention of the state in providing institutions or regulations in a great many aspects of social and economic life which has marked in most western countries a critical characteristic of the period since the wars. While the shorthand term 'welfare state' has won commonplace acceptance, the term itself and the body of state policies which it

represents have at the same time been the object of intense academic and political debate.

Health services in the postwar world, in Britain perhaps more than anywhere else, form an important part of the general body of welfare state provisions. In the crucible of the war, the dysfunctionality of a vast number of archaic laws, practices and attitudes became critically obvious to workers, planners and reformers, and political and economic leaders of all political orientations.

The state had already reorganised vast areas of economic and social life for the waging of the war; it was clear that unless many of its major interventions were maintained in some form in peacetime, a reversion to prewar economic chaos and insecurity would probably result. This would have predictable consequences in political instability and radicalisation, as had been the experience after the First World War. The state would be, in peacetime as in war, the only agency of sufficient means and overarching authority to create a new or renovated series of social provisions and institutions adequate to the purpose of ensuring stability, security, and adequate standards of health and education in the 'national interest'. It was clear that new social and economic provisions would be, in some fashion, in the common interests of both workers and industry (capital), and of political stability. A new postwar political compromise, or settlement would be attempted among the major social forces -- labour and capital -- with the active assistance of the state.

It is in the context of the 'postwar settlement', the major organisation of large areas of social and economic life, that the welfare state, and, as a part of it, the NHS, is seen in this study.

The term 'welfare state' has been the subject of much academic discussion. Maurice Bruce traces the origins of state intervention in social policy to the Elizabethan Poor Laws; the term itself might be traced to Bismarck's social insurance scheme of the 1880s, referred to as the 'Wohlfahrtsstaat'; in Britain, though it was used minimally in the interwar period, it was not widespread until the popular reaction to the Beveridge Report; in the United States, it came to be used as a derogatory term by conservative opponents of state intervention in the late 1940s. (22)

Richard Titmuss has referred to "the indefinable abstraction 'The Welfare State'," noting the lack of agreement over its meaning, and the dangers of such terms concealing more than they disclose. He has, however, paid a great deal of attention to eliciting the essential principles of state policies which represent "collective interventions to meet certain needs of the individual and/or to serve the wider interests of society." (23) Maurice Bruce, in a definition which perhaps vindicates Titmuss' warning against the too-general use of the term, considers the welfare state ". . . the sum of efforts over many years to remedy the practical social difficulties and evils of a modern system of economic organisation which grew with but little regard for the majority of those who became involved in it. . . ." (24) He goes on to identify those difficulties and evils as endemic to early British industrial capitalism, and concludes that, in the welfare state, society has created, in effect, the means to remedy its own problems. This of course begs the question of the effectiveness of the means and the intransigence or structural nature of the problems.

Dorothy Wedderburn notes the view prevalent in sociology that the

welfare state is a common phenomenon of all capitalist or industrial societies, as part of the logic of industrialisation. There is agreement, she says, that the term implies a state commitment to modify market forces in order to ensure a minimum income for all by insuring against incapacity to work; to guarantee the provision of education; and to guarantee treatment and benefit for sickness and injury. There is less agreement as to whether redistribution of income should be one of its goals, and much evidence that little if any redistribution has occurred. She identifies four groups of theories of the welfare state: (a) the anti-collectivist school of liberal economics; (b) functionalism; (c) the 'citizenship' view; and (d) the integrationist school. The latter three schools, which approve of a broad range of social interventions by the state, agree in the interpretation that welfare state measures are of benefit both to individuals and to the economic and social system. They differ in their emphasis on the role of class and class conflict, justice and fairness, and progress toward equality. But they share a good deal of common ground in seeing the welfare state as serving to ameliorate fundamental social conflicts and inequalities.

While there may be agreement among these schools on the functions of welfare state policies, there is relatively less agreement on their origins and perceived purposes. Wedderburn herself stresses the historical and political aspects of the creation of the welfare state, noting some of the unique circumstances of Britain after the war. She accepts the view of Titmuss and Professor T. H. Marshall that the welfare state represents one stage in the completion of a formal equality (but not necessarily substantive or thoroughgoing) of status,

civil, political and social, implying equal rights and access in these areas, as the foundations upon which structures of fundamental economic inequality could remain.

Marshall, as an exponent of the 'citizenship' school (i.e., the gradual expansion of the formal rights of citizenship) sees greater areas of formal social equality (e.g., the NHS with its universal, free and equal accessibility) being created as a process of reducing, bit by bit, the deep social inequalities of capitalism. But Marshall, although recognising an essential conflict between universalist principles of state social provision and competitive principles of market capitalism, along with Titmuss, has no adequate explanation of the reasons why universalism might triumph to a greater or lesser degree in certain state policies. Titmuss, Wedderburn notes, has produced a revealing model of the effectiveness of interest groups on legislation, but he does not consider ". . . any notion of class conflict as crucial in creating the overall balance of political forces which determines whether or not social legislation is enacted, or has an influence upon the final form of that legislation." In contrast, Ralf Dahrendorf, representing an integrationist approach, suggests that the increases in social rights implicit in welfare state policies are in reality part of the process of institutionalising class conflict, integrating, channeling and limiting, rather than eliminating it.

Wedderburn concludes that the welfare state should not be analysed as a static entity -- its nature changes with the balance of political forces, in particular with the balance of class forces: ". . . there is nothing about any of the particular bits of social welfare legislation which is specifically or 'essentially' socialist. At all points, the

actual effect of welfare legislation (i.e., whether it contributes to a reduction of inequality), the values embodied in welfare legislation (i.e., whether it is fair shares for all, or help to those who have paid), represent a compromise between the market and laissez-faire on the one hand, and planned egalitarianism on the other." (25)

T. H. Marshall himself, in a vignette illustrating Bevan's own view of the compromise of social forces and principles inherent in social policies, poses the question of "whether the measures taken in the field of public health were a natural fulfilment of Victorian democratic capitalism or an attack launched against it. Aneurin Bevan took the latter view, but he qualified it by adding that the system was quick to claim the credit for what had been imposed upon it by its attackers. Public health measures, [Bevan] said, have become part of the system 'but they do not flow from it. They have come in spite of it . . . In claiming them, capitalism proudly displays medals won in the battles it has lost.'" (26)

The point is made, through Bevan's irony, that in the incomplete resolution of the social conflicts which resulted in the Victorian and later health reforms, protagonists representing both the status quo and reform were able to claim at least partial victory.

A more critical approach to theories of the welfare state is presented by Ian Gough, who examines sociological functionalism on the one hand, and welfare economics and political pluralism on the other. He finds these three groups of theories lacking, primarily in their failure to take into account historical and social class factors responsible for the generation of an interventionist social policy by the state, and in their assumption, particularly in the case of pluralist theories, of a

state neutral amongst a plethora of contending interests. He concurs with Wedderburn that the balance of class forces must be looked at in assessing why social legislation is enacted at a particular time, and why it takes the form it does; pluralism is unable to explain or rank the power of interest groups, and cannot identify the social origins of dominant ideologies leading to consensus on various policy issues. (27)

Counterposed to these three groups of theories is a theory of the welfare state based on Marxist political economy, taking as its central concern, in Gough's words: "the relationship between the economy -- the way production is organised -- and the political and social institutions and processes of society . . . [in] particular . . . the relationship between the capitalist mode of production and the set of institutions and processes that we call the welfare state." This theory uses the Marxist model of conflict or contradiction to explain the dual nature of the welfare state, that it "simultaneously embodies tendencies to enhance social welfare, to develop the powers of individuals, to exert social control over the blind play of market forces; and tendencies to repress and control people, to adapt them to the requirements of the capitalist economy." (28) The welfare state, in this paradigm, has the apparently contradictory or dual functions of mitigating the inherent dysfunctional aspects of social relations and conditions (i.e., the "relations of production") of capitalist society, and protecting or enhancing the accumulation of surplus or profits in the economic realm of capitalism (i.e., intervening in the "forces of production").

The 'state derivation' ('Staatsableitung') debate is a relatively recent debate among German Marxist scholars, introduced to Britain by Holloway and Picciotto. One of its central theses is that the state is

derived, in function, ". . . from the inability of capital, as a result of its existence as many mutually antagonistic capitals, to reproduce the social nature of its own existence: to secure its reproduction capital requires a state which is not subject to the same limitations as individual capitals, and which is thus able to provide the necessities which capital is unable to provide." (29)

The 'state derivation' debate is directed toward a logical, theoretical explanation of the relative independence or autonomy of the state from the particular interests of capital. As an explanation grounded in logic, it thus certainly begs the question of the unique historical and political manifestations of the state and its various social interventions in relation to capitalism and society.

The 'relative autonomy of the state' from the direct control of capitalist interests is a position now accepted by many western Marxist theorists, in reaction to the traditional Marxist concept of the state as merely the executive arm of the bourgeoisie, this latter notion being considered incorrect, indeed 'vulgar' in its oversimplified caricature. The nature and degree of 'relative autonomy' of the state, however, is still very much under debate, as has been noted above.

Health and the Political Economy of the Welfare State

It has been postulated that the state supports the economic and social system through its 'welfare state' functions. We shall look at three mechanisms through which this occurs, their implications for health policy; and for the social reorganisation of health:

- (1) the state's role in providing the social conditions conducive to capital accumulation;

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- (2) welfare state functions and the reproduction of labour-power;
 - (3) the role of the welfare state in furthering the legitimation of the social relations of capitalism.

These areas are, of course, closely related, but divide roughly in terms of emphasis, into the economic, social, and political and ideological effects of the welfare state in capitalist society.

(1) The Welfare State, Capital Accumulation and State Health Services: While there is general agreement that the schemes making up the welfare state are functional politically for social stability through guaranteed security for the working class, there is disagreement in Marxist theory over the extent to which they affect the central economic process of accumulation of surplus within the capitalist sector, since the provision of state social services must be paid for through taxation, which comes directly from capitalist enterprises, or from wages, hence indirectly from capitalist enterprises. Social services thus funded through taxes, which are of direct benefit to workers and others, are often referred to as the 'social wage'. The theoretical dispute is over the extent to which the 'social wage' ultimately aids capital accumulation, or is a burden upon it.

There are two main positions in this economic debate. Ginsburg argues that the cost of state social expenditure is borne solely by capital, including that part paid by workers in income taxes. Schatzkin too takes this position, as do Fine and Harris, who go one step further in denying the concept of social services as a social 'wage', since, unlike money wages, they have no exchange value in relation to commodities.

The opposing point of view is taken by Gough, who argues that

social services do represent a 'social wage', and that "the welfare state redistributes income WITHIN the wage- and salary-earning class (the working class, broadly conceived), not from the upper and upper-middle classes downwards, and certainly not necessarily from profits to wage incomes." He, however, makes a distinction between welfare services as cash benefits, terming these a 'social wage', and direct services, which he terms 'collective consumption'. Added together and added to the money wages, these represent the total value of labour power, i.e., the amount necessary for capital to pay as wages both to the worker and to the state to ensure the daily and generational reproduction of labour power. If the social services, whether in cash or in kind, are included in this amount, they must perforce represent not an extra burden on capital, but a redistribution within the wage sector. "This redistribution of payments for labour need not necessarily encroach on the share of profits or surplus value in total output." (30) To what extent the costs (and benefits) of the welfare state, or the NHS, might or might not encroach is a subject for detailed economic analysis beyond the scope of this study.

We are here interested in the political aspects of this question, therefore it is appropriate instead to look at a political interpretation of the role of a health service (as part of the broader social services) in increasing the efficiency of production. The assumptions of the extremely limited provisions of the National Insurance Act of 1911 indicated the purpose of the plan: to return to productive work the sick or injured worker as soon as possible with a minimum of expenditure. Under the basic scheme, only general practitioner treatment was included, not specialist or hospital care,

and dependent family members were not covered. Although some extra coverage was available through the Approved Societies, families had to bear a large burden of uninsured health costs, or go without care. It was recognised by critics of this scheme, and certainly by Beveridge, that the accumulated individual costs of this uninsured treatment, or of lack of care leading to premature incapacity or death, added up to a vast social cost and loss of productive capacity.

The argument of Beveridge, of Political and Economic Planning (PEP), and of the advocates of extensive state social and health services, was that rationally organised services, available to all, and emphasising prevention, early treatment, a full range of care, and rehabilitation, could not but reduce this social burden of prolonged ill-health and misery leading to the incapacity of workers, poverty of families, and poor health among the children who were the country's future workers, soldiers and homemakers.

Beveridge treated the financial aspects of the recommendations for comprehensive social security, including health services, as primarily a matter of national redistribution of expenses already necessarily incurred by individuals, with the state bearing the only significant extra burden. (31) His 1942 estimate of 170 million pounds to be spent by the state on a comprehensive health service compares closely with the 1936 estimate by Political and Economic Planning (PEP) that 150 million pounds were being spent at that time by all agencies and individuals on all health services. In 1937 they noted the loss of 30 million working weeks per year for absences of longer than three days for workers covered by National Health Insurance, most of this due to poor diet, housing, and bad working conditions. PEP suggested that "millions of

pounds are spent in looking after and trying to cure the victims of accidents and illnesses which need never have occurred if a fraction of this amount of intelligence and money had been devoted to tracing the social and economic causes of the trouble and making the necessary readjustments." (32) They thus stressed prevention, rational organisation and free access to services as key principles to eliminating a vast waste of human and financial resources on preventable ill health. Herbert, using PEP figures, estimated the annual cost of treating ill-health in Britain, including not only personal medical costs but public health and environmental service expenditures, to be 300 million pounds. (33)

While the actuarial figures in the Beveridge Report, the PEP Report and the 1944 White Paper were only estimates of the total cost of a health service compared with amounts spent by individuals and local and central governments, the argument was made strongly that even if the amounts were roughly equivalent and the benefits difficult to calculate, the money would be much more efficiently spent in a comprehensive, prevention-oriented health service. This argument, in the context of wartime enthusiasm for rational planning, had a considerable following across the political spectrum. It was widely assumed, even though there was no general agreement on actuarial or cost-effectiveness estimates, that plans such as Beveridge, PEP, and the 1944 White Paper recommended would be the most efficient, and in the long run least costly way of spending the nation's funds on social and health services.

We may, for purposes of analysis, assume certain features of a model organisation of health services most suited to attaining Kelman's concept of 'functional health', a standard of health related primarily

to maintaining productive capacity at minimum cost, or, with minimum detrimental effect on capital accumulation. Such a model would have resembled most clearly the extended National Health Insurance proposal of the major medical, insurance, and private hospital interests during the planning process. This model, in its pure form the most conservative of the alternatives, was not supported by either of the governments concerned in planning the NHS -- Labour or Conservative (although the Conservative party was divided), so had little chance of being enacted.

The opposing model, the preventive, comprehensive and universal scheme, run entirely by the state, proposed by the advocate groups, would have most nearly embodied Kelman's concept of 'experiential health' -- attainment of the maximum personal capacity and fulfillment of all individuals, a state of ideal health, although the advocate groups did also argue the efficacy of their proposals in terms of national productive efficiency. (34)

Although in principle it was much closer to the model of the advocate groups, the NHS as enacted and amended was something of a compromise between the two models. We may thus assume, from the theoretically opposing economic points of view of capital accumulation and of ideal health for the whole population (productive and non-productive), that a compromise was reached between the cheapest (in the short run) and most expedient provision for health care, and the most comprehensive and costly. It must certainly be emphasised, however, that this must remain a theoretical observation pending detailed empirical research within the sphere of political economy, a task beyond the scope of the present study.

(2) The Welfare State, Health and Labour Power: Related to but distinct from the issue of the economic burden of state welfare services upon capital accumulation is that of their effectiveness in maintaining a healthy population, such that maximum productivity of workers and minimum financial dependence of the non-working population is obtained.

In the 20th century, the state has intervened actively with welfare state policies, in assisting the 'reproduction of labour power', i.e., both the daily subsistence and the generational reproduction of the work force, through support schemes for the family, the education system, public housing, and health care. (35)

Gough sees such activity as the essential purpose of the welfare state, which he defines as: "the use of state power to modify the reproduction of labour-power and to maintain the non-working population." He adds: "The welfare state is the institutional response within advanced capitalist countries to these two requirements of all human societies." (36)

Clearly, therefore, not just the amount of money spent by the state, but the effectiveness of the services provided, will be critical to the most efficient reproduction of labour power. Schatzkin considers the distribution, accessibility and adequacy of health care to be of fundamental importance to the concept of health as labour power. He refers to concern in late nineteenth century Britain regarding the deleterious effects of poor health, due to poor working conditions and housing, on industrial productivity, and the widespread conclusion at that time that the state must intervene to protect the health of the worker. (37)

A further argument, beyond the scope of the present study, would

link increased industry and state concern for the health of the worker with periods of high demand for productive labour. While we are not able here to investigate this hypothesis historically, it is worthy of note that the emergency conditions of the Second World War had a great deal to do, pragmatically and ideologically, with the urgent planning and nearly universal acceptance of a state health service. A large part of this impetus came from the widely perceived need for healthy war production workers (as well as military recruits), and for a fit new generation to rebuild Britain industrially and socially in the postwar era. A term commonly used at the time was the need for 'national efficiency', implying primarily the work force. Much of this concern is reflected, for example, in the work of Political and Economic Planning (PEP), a highly regarded independent policy research and advisory body. PEP sought in its review of health services to bring the principles of equity and efficient planning to bear, among other things, upon the problem of poor health as it affected both current national productive efficiency, and the health of the next generation, which would inherit the task of rebuilding Britain. (38)

We may assume here that the model type of service proposed by the advocate groups, and by PEP in its major review of Britain's health services, was directed to achieving the maximum potential standards of health for all persons: children, workers, housewives, dependants, and the chronically ill or disabled. As such, it conforms to Kelman's criteria for promoting both 'experiential' and 'functional' health. The efficient reproduction of labour power would have been but a part of the functions of a health service structured according to this model.

The argument of those groups wishing to extend insurance-based

services, on the other hand, mainly stressed reduced financial barriers for all low-income persons to existing services, with little attention to the preventive aspects or quality of care, or the reorganisation of services. The significance of such a model then, with respect to the theoretical criterion of its relation to the reproduction of labour power, would have been to provide primarily for the minimal 'functional' aspects of health. Although the plan of these groups clearly went beyond the relatively narrow aims of the 1911 National Health Insurance scheme, and in doing so took a much broader approach to 'functional' health by including dependents and specialist care, it could not be said to have promoted the 'experiential' concept of health.

Both Conservative and Labour Ministers promoted their plans for the NHS, inasmuch as they included comprehensive care, from prevention and education through rehabilitation, as designed to achieve 'positive' health, a concept close to Kelman's 'experiential' health. However, the compromises resulting from the negotiations of both Ministers primarily with the medical profession and in the implementation and amendment of the 1946 NHS Act show a less clear commitment to this concept of health. With respect to the contribution of the NHS to the reproduction of labour power, perhaps the most obvious omission, even at the planning stage, was that of an occupational health service. The purpose of this would have been to ensure both the optimum health of workers at the workplace, and, most importantly, optimally healthy working conditions through elimination of occupational hazards. Another large omission at the implementation stage, was that of the long-promised reorganisation of individual general practice into integrated, teamwork-based, preventively-oriented neighbourhood health centers. These two

omissions, of items which would have been critical in reorganising health services so as to render them medically more effective to individuals and to society can be seen here as a retreat by both Ministers from their announced commitment to 'positive' health, and, at least in theoretical terms, as a matter of lower priority being given to aspects of the NHS specifically designed to promote in the long term the quality and reproduction of labour power.

(3) Health Services and the Legitimation of the Social Relations of Capitalism: Theorists of the welfare state, whether functionalist, pluralist or Marxist, are generally agreed that health and social services, in addition to meeting significant material needs in the maintenance of health and wellbeing and protection from insecurity, also have the ideological effect of promoting social harmony. Functionalism would see the welfare state as a mechanism of social integration; pluralism would see it as the working out of a common set of goals by a diversity of interests; and Marxists, as part of the various shoring up mechanisms through which the state aids in the maintenance of the particular economic order.

T. H. Marshall, as we have noted, sees the welfare state as a victory for the rights of citizenship won over decades of political articulation and struggle by those most in need of its net of security. Titmuss would also subscribe to this view, seeing it -- and especially the NHS -- as a significant step toward the recognition of egalitarian principles in social policy. Most of the early historians of the NHS refer to the wartime atmosphere of social solidarity which bred strong expectations of a more secure postwar world, the state being expected to continue its wartime social interventionist role. The Beveridge Report

in 1942 catalysed both widespread and detailed discussion over health and social security schemes, and helped immeasurably to make concrete the popular expectation of state action.

Beveridge in particular, in advocating the divorce of health services from the individual contributory insurance principle (although not going as far toward a free and one-class service as the socialist health service advocates), added greatly to egalitarian expectations. Between the Beveridge Report and the implementation of the NHS, a period of six years, these popular expectations grew enormously.

Partisan politics, within the constraints imposed until 1945 by the Coalition arrangements, were also suffused with the health and social services debates. The Labour Party took the lead, followed by the Liberal and Conservative Parties (the latter being obviously divided on major questions of principle), in advocating massive state intervention in the social services. There were, however, significant differences in principle in the type of state intervention advocated, particularly with respect to health. The Labour Party had adopted the Socialist Medical Association scheme for a universal, tax-supported, free, state owned and organised service. Notwithstanding the commitment of the Conservative Health Minister, Mr Willink, to a universal health scheme free at time of use, it would probably be fair to say that a majority of the Conservative Party would have supported a plan such as that proposed by the BMA and BHA, basically an extension of National Health Insurance to only ninety percent of the population, with retention of facilities under existing ownership. The differences at the level of party programme, of course, corresponded to deeper differences in political philosophy between the advocates of a universal, tax-financed, versus a

restricted, insurance-based service.

Health services were part of the economic and political planning arrangements during the Second World War among the state, employers, and trade unions, known as tripartism. With Beveridge's blueprint for health and social security services, and the promise of planned full employment, the labour movement was expected to commit itself, through joint planning machinery, to industrial peace and wage restraint. According to Gough, "This formed the basis for the 'post-war settlement' between labour and capital in the late 1940s under the new Labour Government," and in effect laid the political foundations for the welfare state. (39)

Ginsburg comments on the verdict of Richard Titmuss that Labour's postwar welfare measures were inspired by the desire to create equal standards and opportunities for all in social services, to promote social integration, self-respect, and more equal social relations without class distinctions:

The welfare state is thus conceived as the crucial apparatus, though incomplete, for putting individual citizenship and the unity of the nation before class loyalty and organisation, and therefore mitigating the effects of class conflict and inequality. This is clearly an expression of the now predominant tendency within the ideology of British Labourism that has sought to establish the Labour Party as capable of offering national leadership and promoting class harmony not least through welfare reform. The welfare state tempers the disquieting effects of inequalities and 'diswelfares' among citizens, setting aside the fundamental class inequality inherent in the capital-labour relation. . . . Hence the welfare state is conceived within the predominant ideology as a historic act of collective altruism, which serves to integrate the citizen into society and to meet his/her needs as they are recognised by the collectivity. (40)

Although the NHS is now assumed in popular ideology to be nothing if not a 'victory for the working class', one must certainly examine the

rival ideological principles and processes of its founding in the course of further analysing its political character.

Ginsburg suggests "that while the welfare state is a response to the presence and pressures created by the working class which obviously goes some way towards meeting basic needs, it does not represent a victory for socialism nor . . . is it a realm of the state over which the working class has established real control." He refers to the dual character of the state, which "is nowhere more apparent than in the area of state welfare, where the demands of the working class have produced important material gains; but those demands have been processed and responded to in such a form that, far from posing a threat to capital, they have deepened its acceptance and extended its survival." (41)

T. H. Marshall, making an analogous point with respect to early Conservative support for state welfare intervention, quotes Arthur Balfour: "'Social legislation, as I conceive it . . . is not merely to be distinguished from Socialist legislation, but is its most direct opposite and its most effective antidote.'" (42)

Of all the pieces of postwar social legislation which exhibit this dual character, the NHS is arguably the most egalitarian in principle, the feature which has perhaps given it the greatest popularity among the social services, even though in practice it did not sweep away the inequities and class biases of the old system to the extent promised by all three Ministers responsible.

Several features of the health service models had particular ideological significance under the political circumstances of wartime social solidarity and reconstruction enthusiasm, and might have been expected to enhance the role of the NHS in legitimating the larger

social and economic system. A one-class service, available to all without discrimination according to means, was perhaps the foremost criterion of political popularity; this would end the invidious class distinction between private medicine and the inferior quality of existing public medical care. Almost as important was the question of equitable distribution of high-quality services, especially in industrial and rural areas, which were badly underserved. There was, as Eckstein points out, an inequitable distribution both of disease and of medical services, by social class, which were in obvious need of redress through a redistribution and co-ordination of medical services. (43)

The existing medical services were seen to be unduly hierarchical by practitioners, general health workers, and the public; democratisation would clearly augment the popularity of a new health service with the majority of persons in these categories, if not with the relatively privileged minorities. Uniform collective bargaining rights for health workers, and participation in management of services, were issues pressed strongly by the advocate groups, and supported strongly by existing health workers' organisations. The inclusion of health education, prevention, occupational and rehabilitative services would, if included, reinforce the ideological impression that the service was designed to ensure the attainment of the highest possible level of health for all persons, and especially for those least well served under the old system.

Such a model scheme, which was clearly oriented to achieving high standards of health with socially equitable access, and democratically organised, would, in addition, have corresponded to Kelman's concept of 'experiential health'.

In principle, then, the NHS as implemented represents perhaps the most democratic of the postwar social measures, and as such it has great ideological significance. But it is clearly a compromise between the two models of the social organisation of medicine. Many of the extremely popular principles of the advocate groups, also held among the senior Civil Service advisors to the Minister of Health, were incorporated into the scheme, virtually from the start of planning in 1942. Those egalitarian general principles, such as free, universal and equal access, have, through the subsequent history of the NHS, remained among its most popular features, and have come to represent an ideological hallmark of the British welfare state, despite complaints regarding adequacy of resources and failure of the NHS to live up to its ideals. It is undeniable that the NHS, although not corresponding entirely to an ideal model calculated to win fundamental working class approval, and despite a chronic lack of financial resources, has helped build a foundation of political loyalty to the general principles of the welfare state, and indeed to welfare capitalism, as it represents the Labour Party's coming to terms, in its 'post-war settlement', with the exigencies of a private economy, the power of the medical profession, and the popular demands of the labour movement.

The Representation of Interests in State Policy Making

We have earlier commented upon and rejected the pluralist notion that state policy making is a direct result of the competition of contending, organised pressure groups, with the state acting as a more or less neutral arbiter of this process. Rather it has been argued that because of combinations of certain economic, social, political and

historical factors, some interests enjoy a structural advantage which results in the incorporation of their positions and policies by the state.

Eckstein has made the case that the BMA enjoys such a position of strategic advantage because of its traditional prestige and as the near monopoly representative of organised medicine. At a more general level, and referring to the state itself, Miliband speaks of the 'bias of the system', the tendency of the state, regardless of the government in power, to accept and work within the ideological and economic constraints of the surrounding private economy, to pay greater attention in policy-making to interests organised on the basis of property.

Marc Renaud describes a similar 'structural constraint' upon the state with respect to medical care, suggesting that in societies in which much illness is occupational or environmental, and where medicine is privately organised, not addressing the social correlates or causes of illnesses, the state is severely restricted in the ultimate effectiveness of any interventions because of the entrenched power of the private economic and professional interests oriented to the status quo. (44)

Samuel Beer suggests that because of the programmatic nature of the Labour Party, it was in a strong position to gain more power for the labour movement in the post-war 'social contract'. Beer sees the origins of this power not just in the 1945 Labour election victory and the party's comprehensive social and economic programme, but in the forging of the party's 'social contract' as early as 1940, with the incorporation of labour representation in government economic decisionmaking -- the tripartism of Labour Minister Ernest Bevin, which

achieved a new and lasting adjustment in the balance of power between classes. (45)

Ian Gough, on the other hand, suggests this new power was more apparent than real. He notes the partial congruence of interests between capital and labour, each for opposing reasons, in wartime industrial peace and in postwar state intervention in welfare, but finds that the compromise, established as an assumed harmony of interests, was extremely illusory. State intervention in social and economic security was irreversible, as was its commitment to full-employment policies, but Gough argues that the representative power of labour within the new structure of state intervention was not commensurate with its role as beneficiary. It is Gough's interpretation that the more important political function served by the 'postwar settlement' was a "regeneration of capitalist social relations", with the full initial participation of social democratic and trade union leadership, which had the effect of reducing militant pressures for more drastic economic change. Not until the 1960s did the labour movement take particular advantage of its increased bargaining power in policy making, he says. (46)

Ginsburg develops a similar theme, that the role of labour in initiating and planning the welfare state is much less than assumed in the commonly held myth surrounding it:

It is true that the support of the organised working class has been crucial to almost all progressive reforms, but one cannot argue that the welfare state is the product of a consistent mass campaign by the working-class movement. The labour movement has never in fact developed and promoted a programme of state welfare measures.

He notes the incorporation of Labour Power and TUC leadership into

the state apparatus in the period after 1940 of reconstruction and postwar planning. That involvement, combined with "the continued absence of a distinct and comprehensive socialist welfare programme," makes it difficult to determine the precise contribution of the labour movement. While the movement exerted pressure on its leaders and on the government for improved conditions, pressure which was politically effective with respect to the state's general commitment to new social policy,

. . . the planning and implementation of the reforms were left to individuals and groups largely outside the Labour movement and the working class. Labour party and trade union members did of course discuss the reforms, but they were delivered 'from above' in the form of government reports and so on, and the Labour movement gratefully accepted the deliverance in the absence of their own programme and in the concomitant rejection of more fundamental, socialist proposals for change.

Ginsburg credits the Labour Party's commitment to its interwar policy programme for the determination with which the postwar Labour government implemented its welfare state schemes after 1945. But the real authors of the government policies themselves "were in fact the progressive, liberal bourgeois who had become committed to Keynesianism and the interventionist state in the crisis of the 1930s. The interpretation and implementation of the post-war legislation, as well as its design, were left in the hands of civil servants and professionals, whose class bias, particularly in the upper echelons, remains unshaken." "We must conclude," states Ginsburg, "that the working class through the organs of the trade union movement and the Labour Party has exerted very little 'real' as opposed to 'formal' control over the shape of welfare policy and administration. . . ." (47)

Since the representation of working class interests in Labour Party

policy making is one of the critical questions of social democracy and the welfare state, clearly a more systematic sociological approach must be taken. We look at three models here.

George and Wilding distinguish two stages of state policy formation in a model which sees social policy arising out of situations of problems or conflicts "involving (primarily) the economic interests and value systems of competing population groups and social classes." They assume that an inherent class conflict exists between "the working class and the upper class" involving more or less constant working class pressure for reforms. The two policy stages are first, the initial recognition by the state of a problem made manifest through class conflict or pressure, and the general determination to solve the problem; and second, the detailed formulation of policy in which the groups whose values and interests are to be affected attempt to influence legislation, or to redefine the situation through policy changes to their own advantage. Here, there is a form of articulated conflict between pressure groups representing working and upper class interests in the area of the social problem in question, and compromises are reached in the detailed policy solutions, generally in accordance with the power and effectiveness of the groups concerned. George and Wilding cite the 1911 National Insurance Act, the purpose of which -- income security -- "was the result of both actual and potential class conflict," whereas the method -- contributory insurance involving private insurance schemes and limited coverage -- reflected the relative power of the interests involved.

The second stage of social policy formation acts as a check to the victories of the working class. When one also bears in mind that the actual implementation of social policy legislation generally falls short of its

stated intentions, the limited effects of social policy provision on the stratified nature of society becomes clear. The distribution of economic and political power in society is such that if social policy is to improve, even slightly, the conditions of the working class, it must adopt a policy of over-kill. . . . It is a corollary of the thesis that the values of the dominant class are the reigning values in society and that the definition of social problems owes more to the values of this class than to the larger but less powerful class of working people. (48)

Robert Alford takes a more structural approach to the representation of conflicting interests in policy formation, in a historical study of health reforms in New York City. He describes three types of interests materially concerned with policy changes, according to their structural relationship to a central decisionmaking power. These are dominant, challenging and repressed structural interests. (49)

A structural Marxist theory of the representation of external interests within the policymaking apparatus of the state is developed in a recent work by Rianne Mahon. Her analysis seeks to locate the disproportionate weight of certain conflicting interests outside the state within a parallel, and equally disproportionate, structure of representation of interests within the institutions of the state. This 'unequal structure of representation' involves, concretely, the particular historical relationships between the various representative organisations of capital and labour with their counterparts in the senior policymaking offices of the state: the Cabinet, individual Ministers and their political advisers, and senior civil servants.

The assumption is made by Mahon, in common with recent Marxist theories of the relative autonomy of the state, that, although the fundamental functions of the state are to serve the general economic conditions necessary for the accumulation of capital and the social

conditions conducive to the legitimation of capitalism, the state must remain 'relatively autonomous' from the plurality of major competing capitalist interests, regulating conditions of competition, defining the common interest of the 'power bloc' representing capital, and intervening in social welfare in order to mitigate the adverse effects of capitalist economic relationships upon the majority of the population.

The various institutions of the state are seen by Mahon as reproducing the complex and contradictory network of class interests outside the state, in 'civil society', in a form quite particular to each state agency. The difference between direct interest group representation (as in pluralist theory) and 'structural representation' within the state is that the state is bound to consider the relative social and economic power of relevant outside interests, and in fact a relatively permanent set of relationships develop between them in setting policy. The unequal structure of representation and the alliances between state agencies and officials with outside interests, reflects the relative degree of predominance of the 'power bloc' representing capital within each state policy agency. Thus, while the state as a whole is capable of containing conflicting elements of representation, there is a general bias among the policymakers in arranging the compromises of interests necessary to produce a given policy, toward the dominant interests. (50)

The assumption of Mahon, along with Miliband (who refers to the structural 'bias of the system') and Alford (who describes the institutionalised advantage of the 'dominant' structural interests), is that a natural advantage in state policymaking accrues to those

interests which are best organised, have a traditional, institutionalised rapport with state policymaking bodies, and which best conform to the past general policy tendencies or orientations of the state.

In this study we seek to explore the relationships, or effectiveness of representation of those forces pressing for profound change in the state's responsibility for ensuring the health of the population.

We contend, using the three criteria applied to the social aspects of a state health service (its effects upon capital accumulation, the reproduction of labour power, and the legitimation of the social relations of the economic system) that the particular combination of features of the health service are consistent with the structural representation of interests involved, although they do indicate a considerable shift in the social organisation of the health care system toward equality of provision for the whole population and vastly improved access for the working class.

In the following chapters, we attempt to shed some light upon the particular representation of interests involved in the several stages of the planning of the NHS, and to explain some of the apparent paradoxes among the successes and failures of the advocate groups as compared with those of the traditional medical interests.

A Note on Methodology

The historical, or research, portion presented here represents a body of data not yet aggregated or analysed in previous accounts of the origins of the NHS. While secondary sources are used to describe

developments prior to World War II, primary sources are made use of with respect to the specific planning and enactment of the NHS during the years of World War II and the postwar Labour government.

These primary sources consist, in the main, of archival material drawn from a variety of documentary collections, most important of which are the Ministry of Health Service planning files and documents held by the Public Record Office (PRO) and the Department of Health and Social Security (DHSS). Most of this material, because of the thirty-year closure rule, was not open to inspection until the period 1975 to 1978. From these documents it was possible to trace the contacts between individuals and the major organisations involved in the planning of the health service and the Ministry of Health. The Ministry's own evolving plans could also be detailed. Relevant documents of the Ministry of Reconstruction, Cabinet, and Prime Minister's office were also consulted.

In addition to these government papers, the health policy documents of organisations comprising the movement in favour of a health service, and of the BMA, were consulted, with several aims: first, to describe the internal health policy formulation processes of the individual organisations; second, to examine these health service policies within the larger political and ideological orientations of the organisations; third, to elicit from these positions and political strategies some model of the organisations' expectations of government social policy. This latter would then become the basis for theoretical analysis of the relationship between the health service advocacy campaign and characteristics of welfare state policymaking.

Accordingly, archival materials of a number of major organisations

were consulted: the British Medical Association (BMA); the Labour Party; the Socialist Medical Association (SMA); the Trades Union Congress (TUC); the Medical Practitioners' Union (MPU); the National Union of Public Employees (NUPE); and the Confederation of Health Service Employees (COHSE). The archives of these organisations, in addition to providing detailed information on internal policy and strategy debates, also revealed joint policy development efforts and exchanges of views among the chief proponent organisations, as well as with other related or less active organisations. Most importantly, examination of records of these organisations dealing with the government made it possible to reconstruct the parallel evolution of political strategies and policies. This reconstruction provides an historical basis for theoretical analysis of the organisations' concerns and the two governments' responses, and of the representation of interests in state policy making.

The role of organised groups is analysed, but, as noted earlier, not in isolation from the sociological context. Indeed the theoretical orientation here adopted is the relationship between the state and the variety of social forces militating toward its adoption of a national health service. Some of those forces comprised organised groups. Other factors, both structural and ideological, included the disorganised and maldistributed condition of medical services, the financial crisis of the voluntary hospital system, the medical exigencies of war, and the ideology of social solidarity of wartime which came to be expressed in an almost generalised working class opinion in favour of a state medical service. Organised groups, especially those representing the labour movement, undoubtedly played an important role in articulating the

problems of existing insurance and health arrangements, proposing models of a national service, and engaging in educational, publicising and organising activities to bring pressure to bear upon government. A part of their political effect was to reinforce the growing ideological trend among the working class and relatively insecure middle class in favour of welfare state measures. This not only brought concrete pressure to bear on government but began to alter the ideological dimensions of the expectations and obligations between state and citizens.

These effects were of course augmented by a number of official and unofficial reports on the public services, including the issue of a popular edition of a 1937 report on the nation's health service by Political and Economic Planning (PEP), the 1942 Beveridge Report, and a number of regional medical and hospital facilities surveys commissioned by the government, under the Emergency Medical Service, through the Nuffield Provincial Hospitals Trust.

The particular groups leading the campaign for a health service can be seen as representative of the position of organised workers, and of organised socialists, during the historical period under review. The question of what sort of health and social services might ultimately be in the interests of the working class is of course a more abstract one, and one which begs the further question of the priorities of the society, a matter of great interest which can only be considered tangentially here. The health service models posed by the various organisations representing socialists or trade unionists are therefore taken at face value, as the expression of self-interest, idealism and political pragmatism, in the circumstances of wartime reconstruction politics. They cannot be assumed ipso facto to represent a 'class

interest', which must remain a matter for further theoretical debate, beyond their relevance to models of state intervention discussed here. There can be no doubt, however, as to the influence of working class opinion and pressure on welfare state policy; this study is concerned primarily with the extent of that influence.

CHAPTER I -- FOOTNOTES

1. Sir William Beveridge, SOCIAL INSURANCE AND ALLIED SERVICES, Cmd. 6404 (London: HMSO, 1942).
2. Most classical definitions of the state include the police and military, since it is the state which has a monopoly on the legitimate use of force. Miliband also uses this definition: Ralph Miliband, THE STATE IN CAPITALIST SOCIETY (London: Weidenfeld and Nicolson, 1969), p. 54. While we agree with this inclusive definition, we are concerned in this study with policy making processes involving reconciling major conflicts in advance of considerations of enforcement.
3. See for example the by now famous Marxist debate on the state: Nicos Poulantzas and Ralph Miliband, "The Problem of the Capitalist State," pp. 238-262, in IDEOLOGY IN SOCIAL SCIENCE, ed. Robin Blackburn (London: Fontana/Collins, 1972). This debate was carried on over a period of several years in the pages of NEW LEFT REVIEW (NLR): Ralph Miliband, "Poulantzas and the Capitalist State," NLR 82 (November-December 1973): 83-93; Nicos Poulantzas, "The Capitalist State: A Reply to Miliband and Laclau," NLR 95 (January-February 1976): 63-83. Two recent Marxist studies of aspects of the British welfare state are: Ian Gough, THE POLITICAL ECONOMY OF THE WELFARE STATE (London: Macmillan, 1979); and Norman Ginsburg, CLASS, CAPITAL and SOCIAL POLICY (London: Macmillan, 1979).
4. James Stirling Ross, THE NATIONAL HEALTH SERVICE IN GREAT BRITAIN: AN HISTORICAL AND DESCRIPTIVE STUDY (London: Oxford University Press, 1952); Almont Lindsey, SOCIALIZED MEDICINE IN ENGLAND AND WALES (Chapel Hill: University of North Carolina Press, 1962).
5. Harry Eckstein, THE ENGLISH HEALTH SERVICE (Cambridge, Mass.: Harvard University Press, 1958).
6. Harry Eckstein, PRESSURE GROUP POLITICS: THE CASE OF THE BRITISH MEDICAL ASSOCIATION (London: George Allen and Unwin, 1960).
7. Arthur J. Willcocks, THE CREATION OF THE NATIONAL HEALTH SERVICE (London: Routledge and Kegan Paul, 1967).
8. Gordon Forsyth, DOCTORS AND STATE MEDICINE: A STUDY OF THE BRITISH HEALTH SERVICE (London: Pitman Medical, 1966).
9. D. Stark Murray, WHY A NATIONAL HEALTH SERVICE? THE PART PLAYED BY THE SOCIALIST MEDICAL ASSOCIATION (London: Pemberton Books, 1971); Michael Foot, ANEURIN BEVAN: A BIOGRAPHY, VOL. II, 1945-1960 (St Albans: Paladin, 1975), Chapters 3 and 4.

10. Aneurin Bevan, *IN PLACE OF FEAR* (New York: Simon and Schuster, 1952).
11. Lesley Doyal, *THE POLITICAL ECONOMY OF HEALTH* (London: Pluto, 1979); Doyal quotes from P. Corrigan, "The Welfare State as an Arena of Class Struggle," *MARXISM TODAY* 21 (March 1977): 91.
12. Vicente Navarro, *CLASS STRUGGLE, THE STATE AND MEDICINE: AN HISTORICAL AND CONTEMPORARY ANALYSIS OF THE MEDICAL SECTOR IN GREAT BRITAIN* (London: Martin Robertson, 1978).
13. See Margaret Stacey, "The Sociology of Health and Illness: Its Present Stage, Future Prospects and Potential for Health Research," *SOCIOLOGY* 12 (May 1978): 281-307. Stacey presents a systematic, critical review of literature and calls for a sociology of health and illness to replace the narrow professional emphasis of the sociology of medicine.
14. Hans Peter Dreitzel, ed., *THE SOCIAL ORGANIZATION OF HEALTH* (New York: Macmillan, 1971), Editor's introduction, pp. x-xv. [emphasis in original].
15. Martin Rossdale, "Health in a Sick Society," *NEW LEFT REVIEW* 34 (November/December 1965): 82-91.
16. Ronald Frankenberg, "Functionalism and After? Theory and Developments in Social Science Applied to the Health Field," in *HEALTH AND MEDICAL CARE IN THE USA: A CRITICAL ANALYSIS*, ed. Vicente Navarro (Farmingdale, N.Y.: Baywood, 1973), pp. 21-37. See also the collection of articles by Sigerist in *HENRY E. SIGERIST ON THE SOCIOLOGY OF MEDICINE*, ed. Milton I. Roemer (New York: M.D. Publications, 1960).
17. Sander Kelman, "The Social Nature of the Definition of Health," in *HEALTH AND MEDICAL CARE IN THE USA: A CRITICAL ANALYSIS*, ed. Vicente Navarro (Farmingdale, N.Y.: Baywood, 1973), pp. 7-12.
18. Arthur Schatzkin, "Health and Labor-Power: A Theoretical Investigation," *INTERNATIONAL JOURNAL OF HEALTH SERVICES* 8 (1978): 213-234.
19. *Ibid.*, p. 215 [Emphasis in original].
20. Doyal, p. 38.
21. *Ibid.*, p. 43.
22. Maurice Bruce, *THE COMING OF THE WELFARE STATE* (London: B. T. Batsford, 1961), p. 31.
23. Richard M. Titmuss, "Welfare State and Welfare Society," in his *COMMITMENT TO WELFARE* (London: George Allen and Unwin, 1968), p. 124; Richard M. Titmuss, "The Social Division of Welfare," in his *ESSAYS ON 'THE WELFARE STATE'* (London: George Allen and

- Unwin, 1958), p. 42.
24. Bruce, p. 30.
25. Dorothy Wedderburn, "Facts and Theories of the Welfare State," in THE SOCIALIST REGISTER 1965, eds. Ralph Miliband and John Saville (London: Merlin, 1965), pp. 127-146.
26. T. H. Marshall, SOCIAL POLICY (London: Hutchinson, 1965), p. 17.
27. Ian Gough, "Theories of the Welfare State: A Critique," INTERNATIONAL JOURNAL OF HEALTH SERVICES, 8 (1978): 27-40.
28. Ian Gough, THE POLITICAL ECONOMY OF THE WELFARE STATE (London: Macmillan, 1979), pp. 10 and 12.
29. John Holloway and Sol Picciotto, "Introduction: Towards a Materialist Theory of the State," in Holloway and Picciotto, eds., STATE AND CAPITAL: A MARXIST DEBATE (London: Edward Arnold, 1978), p. 20. See also Holloway and Picciotto, "Capital, Crisis and the State," CAPITAL AND CLASS 2 (1977): 76-101.
30. Ginsburg, p. 26; Schatzkin, p. 230; Ben Fine and Lawrence Harris, "State Expenditure in Advanced Capitalism: A Critique," NEW LEFT REVIEW 98 (July-August 1976): 106-107; Gough, POLITICAL ECONOMY OF THE WELFARE STATE, pp. 114-117.
31. Beveridge, SOCIAL INSURANCE AND ALLIED SERVICES, pp. 119-120.
32. Political and Economic Planning (PEP), REPORT ON THE BRITISH HEALTH SERVICES (London: Political and Economic Planning, 1937); S. Mervyn Herbert, BRITAIN'S HEALTH (Harmondsworth: Penguin Books, 1939), is a popularised version of the above report by PEP; PEP, PLANNING 72 (7 April 1936): 2; PLANNING 92 (9 February 1937); PLANNING 110 (16 November 1937): 2.
33. Herbert, *ibid.*, p. 19; Sir Arthur Newsholme, MEDICINE AND THE STATE (1932), quoted in PEP, PLANNING 222 (30 June 1944): 12.
34. Kelman, pp. 7-12.
35. This discussion represents a hypothetical consideration of how a health service, constructed according to different models, might in and of itself affect capital accumulation. As Ernest Mandel notes, there are many other factors related to the state budget and conditions of industrial production which also have significant effects. Ernest Mandel, LATE CAPITALISM (London: Verso, 1978), pp. 480-489. Also see I. Gough, THE POLITICAL ECONOMY OF THE WELFARE STATE, Chapters 2 and 3; Geoffrey Kay, THE ECONOMIC THEORY OF THE WORKING CLASS (London: Oxford University Press, 1977); Ralph Miliband, MARXISM AND POLITICS (London: Oxford University Press, 1977), Chapter II; Norman Ginsburg, CLASS, CAPITAL AND SOCIAL POLICY (London: Macmillan,

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- 1979), Chapters 1 and 2; Cynthia Cockburn, *THE LOCAL STATE* (London: Pluto, 1978), Chapter 2.
36. Gough, *POLITICAL ECONOMY OF THE WELFARE STATE*, pp. 45, 48.
37. Schatzkin, *ibid.*, pp. 217-222.
38. PEP, *REPORT ON THE BRITISH HEALTH SERVICES*. PEP was concerned to promote good health, through efficient and equally accessible services, both for its intrinsic sake and for its economic value, as reflected in productivity.
39. Gough, *POLITICAL ECONOMY OF THE WELFARE STATE*, p. 147; see also Gough, "State Expenditure in Advanced Capitalism," *NEW LEFT REVIEW* 92 (July-August 1975), p. 69.
40. Ginsburg, *CLASS, CAPITAL AND SOCIAL POLICY*, pp. 39-40.
41. *Ibid.*, pp. 13, 19.
42. Quoted in T. H. Marshall, *SOCIAL POLICY*, p. 31.
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43. Eckstein, *THE ENGLISH HEALTH SERVICE*, Chapters 2 and 3.
44. Eckstein, *PRESSURE GROUP POLITICS*; Ralph Miliband, *THE STATE IN CAPITALIST SOCIETY* (London: Weidenfeld and Nicolson, 1969), pp. 77-81; Marc Renaud, "On the Structural Constraints to State Intervention in Health," *INTERNATIONAL JOURNAL OF HEALTH SERVICES*, 5 (1975): 567.
45. Samuel H. Beer, *BRITISH POLITICS IN THE COLLECTIVIST AGE* (New York: Alfred A. Knopf, 1965)
46. Gough, *POLITICAL ECONOMY OF THE WELFARE STATE*, pp. 65-71; "State Expenditure in Advanced Capitalism," pp. 69-70.
47. Ginsburg, *CLASS, CAPITAL AND SOCIAL POLICY*, pp. 7-10.
48. Victor, George and Paul Wilding, *IDEOLOGY AND SOCIAL WELFARE* (London: Pion and Keyan Paul, 1976), pp. 18-20.
49. Robert R. Alford, *HEALTH CARE POLITICS: IDEOLOGICAL AND INTEREST GROUP BARRIERS TO REFORM* (Chicago: University of Chicago Press, 1975), pp. 13-17.
50. Rianne Mahon, "Canadian public policy: the unequal structure of representation," in *THE CANADIAN STATE: POLITICAL ECONOMY AND POLITICAL POWER*, ed. Leo Panitch (Toronto: University of Toronto Press, 1977), pp. 165-175, 192-194.

CHAPTER 10

CONCLUSION: STRUCTURAL INTERESTS IN THE PLANNING OF THE NHS

The creation of the National Health Service has been seen in this study primarily as a process of creating major changes in the social organisation of health in Britain. The concern has been with the major structural changes accomplished, with the social principles lying behind them, and particularly with the representation of conflicting structural interests in the provision of health services, both in terms of the guiding ideology behind their rival health service models, and their degree of actual participation in the planning process.

It is apparent that the health service policies of neither the Conservative nor the Labour governments followed exactly the policies of their respective parties. The process of planning and adaptation of party policy by the two governments owed much, not only to the presence of interest groups concerned with various aspects of health services, but to the relative structural strengths of those interests within the health services and in society in general.

At a level of greater generality can be seen the role of the state, the complex of permanent institutions of government, including the Ministry of Health in this case, in interpreting and responding to the political, social and economic forces of wartime, most of which militated in favour of a universal, comprehensive, regionalised state-run health scheme.

These were the pressures which set some of the conditions and parameters within which both governments were obliged to work. They

were the pressures which virtually obliged the Conservative leadership to accept a more egalitarian service than they might have chosen if they had paid attention to the very vocal sector of the party which wanted only a partial extension of means-tested National Health Insurance. These pressures also made it a more opportune moment for the Labour government to build on the egalitarian principles of public accessibility to the service established by the Coalition, with further structural modifications in the direction of state control -- most particularly the nationalisation of the hospitals.

But, just as there were pressures propelling the Conservatives towards a more radical, egalitarian policy, there were also constraints upon the Labour government which, in effect, prevented it from fully implementing the plan drawn up by its internal policy advisors and ratified by its annual Conferences.

In the light of some of the theoretical considerations introduced in Chapter 1, and the historical material discussed in Chapters 2 to 9, we shall examine here some of the pressures and constraints which made the NHS -- as planned by two governments -- arguably the most democratic of the reconstruction period welfare state measures, particularly in terms of principles of public access, but still not as democratic as its proponents would have liked, with respect to principles of range and purpose of services, and of public and workers' participation in control of the services.

One of the most important systems of parameters and constraints upon change in the structure of health services derives from the elusive relationship between the mode of production of medical services, and the characteristics of the larger economic mode of production. It has been

noted earlier that in Britain of the 1940s, a common theme united these two sectors -- that of state intervention directed towards the goals of economic stability and social security. The groundwork for this new departure was set by the exigencies of the war economy, mass public pressure for postwar social and economic security, the framework provided by Beveridge, and the tripartite (labour, business and state) planning processes established under the Coalition government. In the pre-war medical system in Britain, as in the economy in general, there were many glaring dysfunctional aspects which led to both inefficiency, and to profound public sentiment in favour of greater equality and security.

In the context of the combined economic and social strategy of reconstruction policies, therefore, reforms in the mode of production of health services, or in the social organisation of health, took their place. While the pressures for, and constraints upon change in the health sector were unique to some of the manifest structural problems or dysfunctionalities of that sector, they were also closely related to the demands for and constraints on change in the economy and society as a whole. Indeed many aspects of the pre-war social organisation of health represented a microcosm of wider social and economic structures, particularly the social class disparities in access to services, in control of services, and in the structures of public and voluntary provisions and facilities.

Beveridge, in concert with a large body of public opinion, particularly in the labour movement, wished to reduce or eliminate the Poor Law legacy in the social services, and provide a full range of social security and health services as assumptions, guaranteed by the

state, upon which an economy of full employment would rest. Among the socialist and Labour Party health service advocates, many went beyond Beveridge in wishing to see health services not only guaranteed to everyone, but changed in purpose and structure, as part of a socialist or social democratic transition in the society. These would provide not only equality of access, but a service directed towards preventive and occupational health, radical changes in the labour process of professional and non-professional services, new integrated structures of community medical care, and elements of workers' democracy.

In the socialist reform schema, these features were linked to a wider set of aspirations for the working class for security, equality of opportunity and full employment. In this context, the socialist and Labour position on a health service stressed not just improvements in access to existing services, but improvements to the qualitative aspects of health programmes, with special emphasis on research and prevention in both industrial and community settings. There was a desire among the advocate groups, and a significant sector of society, including the health services trade unions, for substantial changes in the social organisation of health, consistent with their programme for changes, to be undertaken by the state, in the wider economy and society. To reiterate a point made in the first chapter, the demands for changes in the social organisation of health were linked to, or derived from, a different 'social definition of health' itself, one which stressed fulfillment of human potential in addition to increased productivity due to reduction in illness.

For each of the sets of interests involved in the health service debates and planning, it has been argued earlier, from the advocate

groups, through the liberal, pro-universality reformers such as Political and Economic Planning and senior Ministry of Health officials, to the conservative forces of the medical profession and voluntary hospitals, a particular 'social definition of health' could be identified. This would correspond with their chosen health service model, and their particular viewpoint on state intervention in social and economic life.

Thus the discussion of the representation of these various interests in state policy making for the NHS can be seen in part as a question of the extent to which various aspects of their health service models were opposed or accepted. In addition to this relatively abstract conception of representation is the more practical or immediate form of representation -- the role of the interests, and the state, in the bargaining process itself.

A third concept of representation of interest, discussed by Alford (1) and noted in the first chapter, is that of structural representation, or, in Alford's typology, dominant, challenging, and repressed structural interests. The application of this typology is of some utility in considering changes in the social organisation of health within the larger, surrounding mode of production. This is true since the 'dominant,' 'challenging' and 'repressed' structural interests in the health sector may be delineated, and compared, with respect to influence on public policy, with those in the wider society, or other sectors. Although such a task is well beyond the scope of the present study, it is of interest to note the case of the private insurance industry, an 'interest' deeply involved in several sectors of society, and especially involved in health in the form of approved societies

after 1911. This major financial institution was, in effect, removed from a very significant structural position, indeed a dominating one, with the rejection of insurance as the basis for health care provision in the NHS.

To apply this typology to NHS policy formation, the dominant pre-NHS structural interests may be identified as the medical profession and voluntary hospitals and to a lesser extent the local authorities; the challenging interests as the organised advocate groups including the TUC and Labour party, and the repressed interests as those unorganised sectors of the population not covered by National Health Insurance, or poorly served by the pre-NHS social organisation of health. In the planning, establishment and modification of the NHS, each of these sets of interests interacted with the state, at the centre, to create major changes in the social organisation of health. To a significant extent, the creation of the NHS involved, implicitly, a realignment of the 'dominant,' 'challenging' and 'repressed' structural interests. The elimination of the insurance industry has just been noted -- a consequence of the decision to take the health service 'out of the marketplace' and make it a universal, free state service.

The realignment of the various structural interests can be more clearly seen in relation to several criteria by which the social organisation of health services before and after the inception of the NHS may be described. These criteria are: 1) Principles of public access to services, or degree of universality; 2) Principles of the structure of services, referring to ownership, comprehensiveness, and degree of integration or co-ordination; 3) Principles of representation in administrative control and management, with reference to the degree

of institutional power given the medical profession, non-professional health workers, other agencies, and the public in the operation of the service; and 4) Principles of representation of interests in the planning of the service, (which can be expected to be reflected, in part, in the first three substantive criteria above).

In effect, the first three criteria can be seen as a way of further specifying or breaking down the substantive 'models' of health services held by the various interests, and ultimately decided by the state in the process of policy formation, legislation and regulation. The state also had the deciding role, *ipso facto*, in determining the fourth, procedural criterion, the principles of representation of the various interests both in the planning process, and finally in the institutional structure of the service.

The chief focus in this study has been the extent of influence or representation of the health service advocates, both as partners with the state in the planning process, and on the substantive features of the health service, under the two major governments involved, Coalition and Labour, and the short-lived Caretaker government. The following synopsis recapitulates some of the main points of decision by the governments on the substantive features of the service, and some of the main characteristics of representation of interests in the planning process itself; discussion of the four criteria of representation noted above will be resumed after this brief historical recapitulation.

The Coalition Government

Three major sources of ideas and pressure impinged upon the Coalition in the early years of the war: the Draft Interim Report (1938)

of the BMA-sponsored Medical Planning Commission; the popular Beveridge Report (1942); and the proposals of the various advocate groups for a socialised service. The BMA Council and a part of the Conservative Party established their support for a limited extension of National Health Insurance in the period between 1942 and the issue of the 1944 White Paper. In effect, the various interests were just beginning to organise their positions and tactics at this time.

The first of the two Coalition Health Ministers, Ernest Brown, accepted the Beveridge Assumption that the state must provide a universal service, with no discrimination by financial status. Brown did not hold the view of the Labour Secretary of State for Scotland, Tom Johnston, that all services should be free of charges. Brown was, however, willing to test the advocates' position in favour of salaried health centre practice and suffered the consequence of fierce opposition from the medical profession. Willcocks suggests that Brown's scheme bore the strong influence of his senior officials, many of whom had experience in local government medical services, and that it closely resembled plans proposed by the National Association of Local Government Officers and the Society of Medical Officers of Health. (2) Brown and his successor Willink lost the issue of hospital charges (supported by the three major voluntary hospitals associations) to the Labour viewpoint in the Coalition, and although he had no more than suggested that salaried service be discussed, he suffered the censure of the medical profession for doing so.

Brown and Johnston were, nonetheless, responsible for much of the groundwork of the 1944 White Paper, a fact now borne out by Cabinet and Ministry documents, but generally unrecognised in previous assessments

of responsibility for original NHS proposals, since the White Paper was published by Brown's successor Henry Willink.

A basic and persisting pattern in NHS policy was established by the Coalition Cabinet during Brown's tenure. The service would be fundamentally egalitarian with respect to public access to it, through the principles of universality and comprehensiveness, and medicine would in all essential respects be taken out of the market; but the egalitarian principle which was applied to access would not extend to control and terms of service, in which the medical profession was to enjoy effective dominance, won by degrees following their first confrontation with Brown.

The Coalition government went far to recast the basic relationships between the state and the various producers and providers of health care; in doing so it established the state in a position to define and regulate the conditions and relations of the production of medical care in the context of a national medical service. Even though, under the 1944 White Paper scheme, half the hospital system would remain private, and most doctors would remain independent contractors, health care was to be seen as a matter of right for everyone, not of insurance for certain income groups. The role of the private insurance industry would be eliminated, and the principle was determined that virtually all health services and facilities would be co-ordinated in a national service.

The Coalition was also responsible for defining the three major groups or blocs of interests with which the government would deal in consulting and negotiating the details of the service. These were the medical profession, the voluntary hospitals, and the local authorities.

While the views of organisations representing the labour movement were noted by the Ministry and government, there is no indication that close negotiation with, or the agreement of the TUC or health services trade unions representing skilled and unskilled health workers, were seen as necessary to designing the scheme despite their vast numerical predominance. The other professions were given a relatively minor role both in discussions, and in the central administrative bodies to be set up to guide the service.

Even though arrangements were not complete by the end of the Coalition for trade union bargaining and representative structures in the NHS, it was clear that the trade unions perforce must negotiate their role in the service only after the government had finalised arrangements with the other three interests.

It was also clear that the substantive or health service policy interests of the labour movement (in health centres, preventive and occupational health, and against incorporating elements of private practice) were not at all accepted as bargaining issues by the government.

The Conservative Caretaker government, during its brief interregnum in 1945, undertook no further concessions from the original White Paper and subsequent negotiations, but it did consolidate decisions in certain important policy areas (e.g., the provisional retention of sale and purchase) and produced a draft White Paper, with the initial assumption that a Conservative health service proposal would be announced before the election. The statements made by Lord Woolton in commending the scheme, with its inherent compromises, to Churchill, as reflecting to a far greater extent the point of view and interests of the Conservatives

in the Coalition than those of Labour, are illustrative of the views of at least part of the Conservative party. Indeed it was stressed in this draft White Paper, which the Cabinet decided not to release before the election, that the essential purposes of a comprehensive, universal health service had been retained, while the changes made during the previous negotiations would ensure a greater degree of freedom for patients and doctors (i.e., a wider scope for private practice), and greater autonomy for voluntary hospitals. (3)

Although Willink claimed the support of the BMA, the tenor of the resolutions passed at its Annual Representative Meeting in early May 1945 make that assumption questionable, and its official support was only tentative. It would also appear, from Lord Woolton's careful defence of the predominant representation of Conservative views in the Coalition/Caretaker proposals, that a part of the Conservative Party suspected undue representation of Labour views and was reluctant to see the negotiated scheme go ahead. (4)

The Labour Government

Bevan's first task, as Minister of Health, in the autumn of 1945, was to evaluate the principles established by the Coalition and Caretaker governments and the concessions made to the independence of the medical profession and voluntary hospitals. He was faced with the choice of retaining the model finally determined by Willink, or making alterations according to Labour Party policy, and the policies of his colleagues in the several advocate groups.

His choices were made in relative isolation from the interests outside government, but, it would appear, with the concurrence, or at

least acquiescence, of his senior permanent officials, many of whom had espoused the principles of a universal service from 1942. Although he held no formal consultations at this stage, Bevan was well aware of the positions of the advocates in favour of full integration of services, salaried payment for general practitioners, occupational or industrial health, and health centres -- in short, the desire to renovate and reorientate medical services into a service for health.

Few of the Ministry of Health documents covering this critical planning period remain; however, among those which do, there is no indication of disagreement within the Ministry with Bevan's decision to nationalise the two hospital systems. In fact, his view that it would be an eminently rational step, solving several major problems in the hospital sector at once, seems to have been shared. It was clear that he was determined to maintain this decision against the most vehement protests of the voluntary hospitals, with the assured knowledge that only by state ownership could a more secure future for all hospitals and for specialist practice be guaranteed. He had been supported in this position by a number of respected consultants. Even though the local authorities were reluctant to lose a major part of their sphere of administration, the municipal hospitals, they were assured that there was equity in the nationalising of the two systems.

The early decision to end the sale and purchase of medical practices was one for which there had been considerable support among Ministry officials under the Coalition, but which it appeared extremely unlikely Willink would support -- notwithstanding extensive discussions -- under the sustained opposition of the medical profession. Although at least some of the Labour members of the Coalition government had

supported abolition of sale and purchase, they did not press the issue in the War Cabinet. Bevan's decision thus affirmed Labour Party policy on this issue. However, like Willink, Bevan, too, was reluctant to press the issue of salaried service, even optional salaried service, upon an antagonistic profession, despite this being one of his party's key points for the transformation of medicine as a state service.

Also like Willink, and despite the sustained requests of both the advocates and the BMA, Bevan refused to open for discussion the issue of an industrial health service and the related issue of the integration of all government health services under one Ministry. These issues, along with that of health centres, to which both governments demonstrated a commitment vacillating between rhetorical support and practical lack of support, were the issues of structural change most important, in the advocates' arguments, for the revolutionising of medical care into a service designed to promote 'positive' health, rather than simply making the traditional curative services more readily accessible.

Bevan's earliest policy decisions -- those prior to the announcements to the interested groups in January 1946 -- were firm decisions which he did not rescind or alter in their fundamentals; and they were, significantly, decisions which went considerably beyond the limits of Coalition policy. Nationalising the hospitals had never been considered by the Coalition, and sale and purchase was showing signs of being retained, with the Coalition's suggestion of a waiting period and an enquiry.

Nationalisation was defensible on several grounds in Bevan's overall strategy: it would relieve the financial crisis of all, but especially the voluntary hospitals; it would facilitate a one-class

hospital service; it would facilitate administration of the hospitals, with one system, regionalised, for finance, policy, personnel, and treatment arrangements; and, not least, it would provide a secure, uniform national base for the employment of medical specialists, a key element in driving a wedge between the specialists and the BMA leadership. Against these substantive factors, the opposition of the voluntary hospitals was a relatively minor matter.

The university teaching hospitals were further placated, and driven apart from the non-teaching voluntary hospitals, by being given special status as the base institutions around which regional hospital services would be organised.

The arguments for this course of action were a blend of Labour Party policy commitments to an egalitarian national hospital service, principles of sound public and financial administration, and shrewd pragmatism in the splitting of the medical profession and voluntary hospital interests. It might be inferred from the small amount of evidence in Ministry files, that Bevan was advised informally by colleagues in the SMA, who would certainly have supported nationalisation. It would appear that he was advised similarly by at least a few eminent consultants, who took the view that nationalisation was the best means of re-establishing specialist practice with a sound economic and organisational base. It is noteworthy that the medical profession's first reaction to Bevan's NHS proposals, the statement of the Negotiating Committee in mid-January 1946, was in favour of the national hospital system, particularly since the local authorities would cease to run the municipal hospitals.

Nationalisation, therefore, is perhaps the clearest case of Bevan's

adoption, and pragmatic use of one of the key positions of the advocates. But while nationalisation undoubtedly served the goal of a unified hospital system, the more general, overriding principle of a unified health service, also critical to the advocates' model, was not revived by Bevan. The final tripartite structure of the NHS demonstrated the tradeoffs made by Bevan and his predecessors with both the local authorities and the medical profession, to secure their participation.

The structural arrangements with the general practitioner service were those which were least satisfactory to the advocates. On most of the policy issues which would have been central to a wholesale reorganising of general practice -- salaries, central regulation of location of practices, and health centres -- major concessions were made to the medical profession. The promise of an Amending Act outlawing general practitioner salaries was one of Bevan's final means of persuasion to the BMA to join the service in 1948.

The extent of Bevan's commitment to health centres has been debated on the basis of interpretations of the 1948 Ministry Circular which relieved local authorities from the responsibility of planning for centres under the NHS Act, and interpretations of the significance of the government's austerity measures of 1947. (5) It is, however, evident that Bevan did not proceed early and decisively with plans for health centres, whatever his personal commitment to the idea, as he had done with the nationalisation of the hospitals. He had, like Willink, agreed with the medical profession that health centres should proceed on the basis of centrally controlled experiments with medical advice, when it was known on the one hand that the profession's commitment was ambiguous at most, and on the other that many local authorities were prepared to

proceed with plans. By the time the question had been given to the Central Health Services Council for its official advice, and budgetary and political restrictions were imposed on Bevan in the Cabinet, the fate of the centres had been decided. It is certainly evident also that Bevan did little at any point to encourage the pro-health centre forces, including the advocate groups or the local authorities, to form a lobbying group to act as a countervailing force against the reluctance of the medical profession.

The 'model' service constructed by Bevan represented, therefore, a hybrid of the positions taken by the advocates and the major interested parties.

Four Criteria of Structural Representation of Interests

To return to the four structural principles of the social organisation of health and representation of interests noted earlier in this chapter -- principles of access, structure of services, structure of administrative control, and of planning representation -- the various interests were, it has been argued, treated differentially. This may be summarised briefly, if not wholly comprehensively, as follows.

1) Principles of public access

In general it may be said here that the 'challenging' and the 'repressed' interests (i.e., the organised advocates and the unorganised and underserved public) fared better than did the 'dominant' (i.e., medical and hospital) interests. This may be demonstrated by the choice, by the state -- under both governments -- consistently to reject the

demands of the medical profession for a ninety per cent service, and the Beveridge recommendation for some user charges, and to accept the advocates' plan of a service covering the whole population without means testing, and without user charges (with few minor exceptions).

It may be concluded that, for the state, the evidence -- political, social, and economic -- was overwhelmingly in favour of equality of access without distinction by means, or the disincentive of fees. It is clear from the documentary evidence of the period, that the chief planning and decision making figures of the state were obliged to make this commitment to the nation's health, productivity and political satisfaction with postwar social programmes; in the face of such a massive commitment to the public welfare, the opposition of the profession and hospitals to universal public access could not take precedence. It is noteworthy also that among the leadership of the two governments, particularly between the two Health Ministers, there were no significant differences over universality, with the exception of that part of the Conservative Party which supported the BMA.

2) Principles of the structure of the health service:

The chief issue at stake here was comprehensiveness, i.e., the inclusion of all services within the NHS. Subsidiary issues included: range of services, whether existing or new; unification under one Ministry, with state ownership, or various schemes of co-ordination; preventive, occupational, and health centre services; and the extent of private practice, and related terms of medical service issues. The views of the 'challenging' interests, the advocates, clearly supported the widest interpretation of comprehensiveness, stressing extension of

preventive, occupational and community services and integration under state ownership. The 'dominant' interests, their power residing in the existing medical and hospital institutions, wished as little disruption to the status quo as necessary, providing a sound financial basis for their services would be guaranteed by the state. They did wish a decrease in the power of the local authorities, and sided with the advocates in wishing to unite all government health services under one Ministry. The issue of professional control over existing services was predominant. It is in the area of the structure of NHS services that perhaps the greatest degree of compromise between 'dominant' and 'challenging' interests (the latter advocating on behalf of the 'repressed' public interest) was arranged by the state.

Here also, differences between the two governments were most apparent. The Coalition government, and its successor the Caretaker government, had planned a system of co-ordination of hospitals which appeared to be the maximum degree of co-ordination tolerable to the municipal and voluntary sector. Bevan superimposed a conception of the public interest consistent with the position of the advocates in overriding the sectoral differences among hospitals by nationalising the two entire systems. When it came to adding extra services to those already provided, for example, health centres, occupational health services and extra research and preventive efforts, however, both governments at most agreed only in part with the advocates, and the commitment to health centres, which did not come to fruition under either government, was finally handed to the medical profession for its not unfamiliar advice. A compromise was also effected in the area of private practice, with Labour certainly going further than the Coalition

in banning sale and purchase of NHS practices but turning down the advocates' position against private practice in hospitals and for whole-time salaries, in favour of payment and private hospital bed arrangements satisfactory to the medical profession or parts of it. It may be concluded that these positions of the 'challenging' interests, even though they argued on behalf of the improved health and productivity of the working class, were not seen by the state as sufficiently overriding concerns to warrant their implementation, against the will of the medical profession. The industrial or occupational health service remains an anomaly, since it was proposed by the advocates and the BMA alike, and rejected by both governments; it may be assumed, until further evidence comes to light, that both were unwilling to commit financial and administrative resources, and to challenge the prerogative of the Ministry of Labour over industrial health, despite the long entreaties of the Labour movement.

3) Principles of the structure of administrative control:

A very clear conflict existed between the medical profession, which wished to maintain and institutionalise a dominant influence, and the advocates, who wished in effect to democratise the division of labour and structures of control in the service. It was the concern of the state, with a certain difference in degree between Coalition and Labour governments, to extend the area of final public responsibility for health services without radically diminishing traditional medical administrative power. The local authorities, as one of the 'dominant' structural interests, were offered the compromise of retaining augmented public health functions while ceding their ownership of hospitals. The

Labour movement was almost entirely rebuffed, even by the Labour government, in its attempt to achieve a significant and institutionalised role in the management and direction of the NHS at all levels, apart from the establishment of Whitley Councils and NHS-wide collective bargaining. Thus the structures of professional and of workers' involvement in the end reflected the original dominant and subordinate positions of these groups.

4) Principles of representation in NHS planning:

This has, in essence, been a key theme of the historical material of this study. Along with the structures of administrative control established in the NHS, it is the area where the influence of the 'challenging' and 'repressed' interests remained weakest. Neither government appeared willing to enter into a new relationship of bargaining with, and offer administrative responsibility to, the advocate groups, in particular the labour negotiations,⁰⁵⁴¹⁰ middle class not covered by National Health Insurance movement, which was ostensibly the greatest beneficiary of a universal, comprehensive service, along with those parts of the middle class not covered by National Health Insurance. In negotiations, both governments, it has been shown, dealt first with the three major or dominant interests, and primarily with the medical profession. Bevan made most initial decisions without formal consultations, then entered into a long period of essentially bilateral discussions with the medical profession. The labour movement, despite the extent of trade unionism in the health services, remained essentially outside this close bargaining relationship; there appeared to be no degree of reciprocity between the

minimal role accorded to the labour movement in planning and administering the service, and either its large degree of industrial power within the service or its support for the Labour government.

Conclusion

The question has been frequently asked, in the three-plus decades of existence of the NHS, of whose interests it serves, or serves best. Is it to be interpreted as a 'victory for the working class,' a 'socialist health service,' or, on the other hand, should it be seen as something primarily functional for the perpetuation of the existing order, a minimal concession to egalitarianism arranged cynically by the state in the interests of social harmony? These questions are truly complex; the approach here has been to provide a structural framework through which such issues may be explored in the historical data pertaining to the founding of the NHS.

It would certainly appear, considering the pattern of representation of structural interests explored here, that the policies themselves may diverge substantially from representation in the process of policy making. Accordingly, it would appear that the substantive gains made by the beneficiaries of NHS services were made, by both governments, through a relatively dramatic change in service delivery policy and final state responsibility without a correspondingly radical change in planning or administrative representation for the challenging interests. The extent to which this situation of structurally differential representation in the health service sector is reflected in other sectors of state policymaking can only be the subject of further fruitful research.

CHAPTER 10 -- FOOTNOTES

1. Robert Alford, HEALTH CARE POLITICS (Chicago: University of Chicago Press, 1975), Chapter 1.
2. A.J. Willcocks, THE CREATION OF THE NATIONAL HEALTH SERVICE (London: Routledge and Kegan Paul, 1967), p. 24.
3. PRO, PREM 4-36/3, C.P.(45)13 and C.M.(45) 9th Conclusions, Draft White Paper, 4 June 1945, and Cabinet Minutes, 15 June 1945.
4. See Chapter 7, note 42.
5. Michael Ryan, "Health Centre Policy in England and Wales," BRITISH JOURNAL OF SOCIOLOGY 19(1968):34-46, takes issue with Eckstein's contention (in THE ENGLISH HEALTH SERVICE, pp. 248-252) that Bevan was not strongly committed to health centres.

CHAPTER 2

FROM THE POOR LAW TO NATIONAL HEALTH INSURANCE

AND THE INTER-WAR REFORM DEBATES

The advocacy of state involvement in the provision of health protection and medical care has its origins as a reform movement in the mid to late nineteenth century. The earliest origins of this advocacy, or of state involvement, might be debated among social historians like the debates among geographers over the ultimate source of a great river.

It is clear, however, that by the mid-nineteenth century sufficient developments were taking place in the politics of public health to say that reform movements were well underway and that the state was being called upon to assume significant responsibility in what had previously been the relatively laissez-faire domain of the private industrial economy, and the medical profession, with some palliative assistance from the Poor Law.

Medical and social historians draw a major distinction between the sanitary and public health reform movement, directed toward measures which would affect the collectivity through regulations and the provision of general services, and the movement to reform personal health services, for example by abolishing the invidious discrimination against the poor of the Poor Law medical services. The former movement typified developments before the turn of the century, the latter, the early part of this century.

Through these two periods, a number of major principles were

established concerning the respective involvements of the state at both national and local levels, the medical profession, private agencies such as insurance companies, and last but not least, the individual, according to his or her economic status.

These principles, and the extent of political debate surrounding them bear direct relation, as antecedents, to the principles and models of a health service debated during the National Health Service planning process of the 1940s.

Since the history of public health reforms, and of the period following the end of the Poor Law in 1929, has been dealt with exhaustively by other authors, we shall deal with them here only in summary fashion, primarily with reference to the political principles of state, professional, private capital, and personal involvement, with the related issue of social class, which provide both continuity and contrast with the World War II reconstruction debates over public health services.

Social Medicine and Principles of State Responsibility

Studies of the social incidence of disease began relatively early in the nineteenth century. Vital statistics were collected with some expertise following the founding in 1836 of the Office of the Registrar-General of Births, Deaths and Marriages. Many prominent physicians were by then serving the government as advisers on quarantine policy, and in parliamentary inquiries.

The most notable of these early state investigations was the Commission of Inquiry into the Working of the Poor Laws, in the 1830s, of which the later renowned Edwin Chadwick was secretary. Chadwick

himself reported in 1842 in THE SANITARY CONDITION OF THE LABOURING POPULATION OF GREAT BRITAIN, an exhaustively documented survey with recommendations. The General Board of Health, a body with relatively weak enforcement powers was set up by Parliament under the Public Health Act of 1848; its public health responsibilities were turned over to the Privy Council in 1858.

Coinciding with this centralisation of powers was the tenure as Medical Officer of the Privy Council (1858-71) of John Simon, who was to articulate state responsibility for health on an entirely new basis. Jeanne Brand comments that Simon "conceived the state's role as that of superintendent-general of health -- an earnest advisor and supervisor of local sanitary administration, ready in the last resort to enforce the law. Acting on this theory, [he] explored new areas of preventive medicine, expanding the basic concept of public health".

These concepts, at the time, embraced mainly central government supervision of sanitary conditions and infectious disease measures. The Sanitary Act of 1866 gave wide powers of sanitary regulation to the local authorities, which would be responsible to the central government for their enforcement.

An entirely separate and backward system of individual care existed in the form of medical relief to the poor meted out by the local Poor Law Boards of Guardians. These Boards paid certain appointed doctors a meagre sum to attend to the certified poor of the parish. The process of application for relief was sufficient disincentive that generally persons only in a very deteriorated condition would apply, with consequent loss of their full rights as citizens, in order to receive the most rudimentary of care.

The zeal for sanitary reform in the medical profession did not at that time extend to the miserable state of Poor Law medical treatment. "The 'sanitary idea', or Chadwick's principle that improvement in the material environment would advance the physical well-being of the English people," Brand comments, "seemed far more important to midcentury sanitary reformers than did the extension or improvement of public medical care." Despite the progress marked by the Sanitary Act of 1866, the confusion of statutes and overlapping of powers still in existence prompted reformers to demand the overhaul and rationalising of the entire complex system.

This need was well recognised in the Privy Council, in no small part due to the enthusiasm for reform of Simon and his staff. Not long after a joint report and memorandum by the British Medical Association and the Social Science Association requesting a comprehensive inquiry, the Royal Sanitary Commission was set up, in 1869, by the new Gladstone government. It reported in 1871, recommending local centralised sanitary and health offices, responsible for both the sanitation and relief of the poor, to be supervised and directed by a national agency of Ministry status. Its recommendations were accepted by government and resulted in the 'three great Acts': the Local Government Board Act of 1871, the Public Health Act of 1872, and the Public Health Act of 1875.

Although the latter consolidated in one Act well over a dozen preceding pieces of legislation, its scope was not sufficient to satisfy the leading reformers, among them John Simon, and the Joint Committee of the British Medical Association and the Social Science Association.

The Joint Committee had considered both the 1872 and the 1875 Public Health Acts minimal in their provision and began, as early as

1876 in a large conference on sanitary measures, to organise new pressure to extend and streamline government supervision and powers.

Along with the great need for sanitary and public health measures which was occasioned by the severe disease epidemics of the late 19th century, went considerable discussion regarding the required extent of state intervention. Legislatively, less progress was made after 1875, and Simon retired early from the medical branch of the Local Government Board, in frustration. There was considerable agitation among Poor Law Medical Officers, particularly through their association, for legislation to improve the nature of their practice.

Among private practitioners, too, there was discussion of state involvement. A number of proposals appeared from the 1870s to the 1890s. While these mainly took the form of proposals for a Ministry of Health, several advocated a national medical service of state-employed personnel, at least for the poor.

Perhaps the most famous of these proposals, Brand notes, was that of Dr Robert Rentoul. The Rentoul plan, debated into the 1890s, would have provided two parallel medical services for the "wage-earning class." One would require a small fee for treatment, the other would be provident, with payments (similar to insurance) made during health. The wide debate resulted in an investigation by the British Medical Association Committee, and a vote by several local branches. All rejected the plan. "The professional organisation of medical men was not willing, however, at this time to accept a 'State Department of Curative Medicine' (for other than the destitute) which might act in competition with their professional interests."

The BMA "... was zealous in promoting many measures which involved

further state control in public health ..." and did watch legislation closely. However, "The British Medical Association never formulated a rigid and permanently applicable conception of the central government's role in public health." (1) It was interested in systematically promoting a medical viewpoint in all levels of government, and to that extent had made a substantial contribution to the development of collective public health measures by the turn of the century. This it had done upon the solid foundations of the statistical and epidemiological data compiled during the numerous investigations into public health and working conditions from the mid to late nineteenth century.

The knowledge of need therefore existed; and legislative reform was being promoted by a large number of energetic and well-positioned persons, both medical professionals and administrators. Even the BMA had been in the forefront of organisational pressure for broadening of central and local legislative powers. But jurisdictions still remained complex, the considerable power and inertia remaining in the Local Government Board's Poor Law administration, and a number of other factors had meant much slower progress than Simon and his fellow reformers had wished. Not least of these was the policy distinction between collective public health reform, and state intervention in personal medical services, which asserted itself in the BMA's strenuous objection to any state medical scheme which would, by setting up a parallel system, threaten the prerogative of the private practitioner.

Health and Social Security as New Political Priorities

The period from the turn of the century to Lloyd George's 1911 National Health Insurance Act was marked by some consolidation and rationalising of existing public health legislation and by several important and searching inquiries into the workings of such 'social' services as did exist, and the extent of need. Several landmark investigations had exposed widespread poverty and subsistence living conditions, notably those undertaken in the late nineteenth century by Charles Booth in London, by Seebohm Rowntree in York in 1901, and by Fabian Society members, in particular by Beatrice and Sidney Webb. (2) The problems of the army in finding healthy recruits for the Boer War had prompted the establishment by the Privy Council in 1904 of the Inter-Departmental Committee on Physical Deterioration, which reported graphically on the deleterious living and working conditions of the poor.

The Inter-Departmental Committee recommended a national advisory council on health, public creches, extended health visiting, medical inspection and the provision of meals for school children. Its Report was taken seriously by the public and by all of the medical bodies concerned with public health.

Many of the concerns of the Report with respect to children's health were dealt with in the 1907 Education (Administrative Provisions) Act, which has subsequently been taken as the beginning of state provision of personal health services on a collective basis. Already by this time many personal health services were provided, in a piecemeal way, by many local authorities. For example, acute infectious disease, diagnosis, treatment and vaccination, free treatment by doctors called

in by midwives, and school doctors and nurses were only a few of many services.

The Fabian Society had produced a voluminous body of material on working and living conditions (indeed Beatrice Webb had worked with Booth on his earlier London studies), but had made few direct recommendations concerning public health until the publication of B. L. Hutchins' "What a Health Committee Can Do" (1908), and F. L. Dodd's "A National Medical Service" (1911). (3)

It was abundantly evident to reformers by this time that the plethora of local authority, private, voluntary and Poor Law health facilities comprised a most inefficient system of overlaps and gaps, the horrifying disincentive of pauper status under the Poor Law, and extremely unequal regional and class distribution of services, and standards of eligibility.

There were also problems with the system of contract practice, the most common form of collective provision for personal medical care, whereby a doctor would, generally for the lowest possible contracted payment, provide care to the members of an informal neighbourhood 'club' or mutual benefit society. Several varieties of these existed, the largest being the 'friendly societies'. Contracts were not regulated, and there was fierce competition among practitioners to obtain them, because of the element of security, despite the fact that the competition kept payment rates very low. The quality of care was therefore extremely variable. The BMA in 1905 recommended an overhaul of the system, with the establishment of local public medical services as an alternative to the variety of contracting societies.

National Insurance: A Battle of Principles

The period of the Royal Commission on the Poor Laws coincided with the planning by the Liberal government of Prime Minister Asquith, particularly by Chancellor Lloyd George, of ambitious measures of social insurance. Several were original in Europe and were politically quite significant as new state initiatives, but their principles of limited access were in due course to be challenged in the ensuing three decades with demands for comprehensive and universal social and health services.

Old Age Pensions, with numerous restrictions on eligibility, were legislated in 1908; in 1909 came the Labour Exchange Act, precursor to unemployment insurance. In the same year William Beveridge published his first major work, *UNEMPLOYMENT: A PROBLEM OF INDUSTRY*, based upon his own investigations and experience in East London. His earlier advocacy of Labour Exchanges won him an invitation from Winston Churchill, then Liberal President of the Board of Trade, to join the Board and supervise organisation of the Labour Exchanges under the new Act. He had seen labour exchanges in successful operation in Germany in 1907, as a supplementary function to Bismarck's social insurance system.

Churchill himself, an influential figure in Prime Minister Asquith's Government, was an avid partisan of social insurance -- indeed he saw insurance as the basis for dealing with both domestic insecurity and political threats from abroad. "Already in 1906 Churchill had defined the Government's social policy as drawing a line 'below which we will not allow persons to live and labour', a phrase and aim obviously inspired by the Webbs' campaign for 'a national minimum of civilised life' and and by the revelations of Booth and Rowntree." (4) The principal of the national minimum was, however, not fundamentally to be

enshrined in the the insurance schemes of the day, which in practice were based on stringent means-tested eligibility, or covered only portions of the working population for a limited range of risks.

As Chancellor of the Exchequer, Lloyd George began preparation for a planned series of insurance and social measures with a budget in 1909 which effected some considerable redistribution of the tax burden from the poor to the rich, the so-called 'People's Budget'. The ensuing opposition of Conservatives and the House of Lords caused two general elections in 1910, the eventual restraining of the veto of the Lords to a delaying power in 1911, and considerable delays to the insurance programs.

G.D.H. Cole notes that Liberal social legislation caused a deep division of opinion in the labour movement between the trade unions and the socialists, a division which reflected a significant difference of opinion on strategies for advancing the interests of the working class. All supported the measures regulating industrial hours and conditions of work, and the non-contributory Old Age Pension scheme. It was the principle of contributory insurance, to be applied in the National Insurance Act of 1911, which provided the point of division. In the socialist view, enunciated vociferously in the Labour Party's campaign for its Right to Work Bill, it was the duty of the state to provide either for satisfactory work, or failing that, for adequate maintenance for its citizens. The Bill "... summed up the Labour Party's conception of the State as a co-operative undertaking with a responsibility for securing to all its members the conditions of a good life." (5)

The National Insurance Bill consisted of two measures: Part II provided contributory unemployment insurance, ostensibly on an

experimental basis, for approximately 2.5 million workers in some of the most seasonal trades. Part I, a long-lasting forerunner of the National Health Service, provided a scheme known as National Health Insurance, contributory sickness insurance for employed workers, for general practitioner treatment only.

Lloyd George had begun preparation for National Health Insurance in 1908, following a visit to Germany, during which he had gained first hand experience of health services and sickness insurance. In late 1910 he delegated the young, reform-minded William Braithwaite of the Board of Inland Revenue to study the German system and prepare a Bill; this was done by early 1911. Discussion of the draft Bill marked the beginning of a series of bitter disputes with both socialists and the powerful insurance interests. The latter were to exact significant compromises in the original Lloyd George plan. It was necessary, through this period, for Lloyd George and the minority Liberal Government to retain the support in Parliament of the Labour Party. One means was to satisfy at least the trade unions (especially considering the high unemployment of this period), if not the socialists.

National Health Insurance: A Conflict of Interests

Preparations for the National Insurance Act are reported to have been well under way before Lloyd George saw the recommendations of the Royal Commission on the Poor Law. He is further reported to have paid little attention to consulting the medical profession in framing the National Health Insurance portion of the Act. (6) The British Medical Association, during the period of the Royal Commission, had recommended locally operated public medical services to "meet the overwhelming needs

of the class just above those aided by the Poor Law" and had proposed to the Commission considerable extension of Poor Law medical care. (7) In 1910 the BMA held extensive discussions on the likely effects of medical insurance on private practice and voluntary charities. This was the beginning of a well-organised pressure campaign which was to last until the coming into effect of National Health Insurance in 1912-1913 and to result in an enduring split in the profession's previous political unity.

National Insurance, including National Health Insurance, underwent much change from Lloyd George's original conception to the Act as passed. The changes were the result of an extremely successful pressure campaign -- even more effective than the BMA's -- waged by the friendly society and private insurance interests. The campaign had a much greater influence than the opposition of the Webbs and other socialists to the insurance principle. Eckstein comments on the enduring effects of the concessions won by the insurance interests: "The vested interests in opposition (the insurance companies) did not prevent passage of the measure, unlike their modern transatlantic counterparts. But they managed to make a shambles of it -- and a considerable windfall for themselves -- by imposing on it an incredibly complicated administrative organization which doomed the system to ineffectiveness, especially from a medical standpoint, from the outset." (8)

The commercial insurance interests were successful in having the primary purpose of National Insurance (Part II) changed from pensions, payable to the family upon death, which they saw as a threat to their own death benefit policies, to the administration of sickness benefit. Since the friendly societies were also interested in administration of

the latter, the two sets of interests were granted the concession under the Act of being able to form 'Approved Societies', the entities to be licensed to administer National Insurance. Even though these were required to be non-profit organisations, the ability to form them was advantageous to both existing friendly societies and private insurance companies, which could recruit more regular business through their part-association with the compulsory, contributory insurance scheme. Although Lloyd George had originally intended only to use friendly societies, which were non-profit insurance associations, the very powerful private companies exerted irresistible pressure, on the one hand to be included as eligible to become 'Approved Societies' and on the other to have widows' and orphans' pensions (and the possibility of funeral benefits) excluded from the National Insurance provisions in order that they might be retained wholly within the private sector. "So it was that pensions, the original object, disappeared, and national insurance became a matter of sickness benefit." (9)

Part I of the Act, titled Insurance Against Loss of Health and for the Prevention and Cure of Sickness, dealt directly with medical care (and very little with prevention). It provided, for employed persons earning less than 160 pounds per year (not for the self-employed or dependents, the rationale being that a worker's uninsured illness might cause the destitution of his family, but not vice versa) compulsory, contributory insurance to cover only attendance by a general practitioner, and medicines (not specialist, hospital, or rehabilitative care).

The BMA, reacting strongly against contract practice with friendly societies and other insurers, successfully pressed for local

administration of the scheme by Insurance Committees, with medical representation. This concession was related to one of the Association's "six cardinal demands," passed at a special representative meeting in June 1911. Other BMA demands specified: a maximum income limit of two pounds per week for beneficiaries; free choice of doctor by patient; benefits to be administered by local health committees rather than friendly societies; the method of remuneration to doctors by the local committee to be according to majority vote of local doctors; rate of remuneration to be approved by the profession; and adequate medical representation on central and local bodies.

By third reading of the Bill in August, 1911, the Government had accepted amendments on all of these points but the two pounds income limit. Royal Assent was given in December, 1911. For the new scheme, administrative bodies were to be in operation by July, 1912, and benefits to patients were to begin in January, 1913. In the intervening period, a determined campaign of medical opposition to the new Act was organised.

In the latter half of 1911, socialist opposition to National Health Insurance was also voiced. The Webbs had been opposed since the new scheme was revealed to them at a breakfast meeting with Lloyd George and the Bill's author, William Braithwaite, in February, 1911: "'Sickness should be prevented, not cured,' cried the Webbs, as they 'singly and in pairs' leaped down Lloyd George's throat." (10) The Fabian Society, Brand comments, was from that point opposed to the Bill, seeing it as a temporary measure serving to circumvent the recommendations of the Minority Report of 1909 for a public health service.

Socialists, Cole notes, "were strongly opposed to the contributory

principle, which they regarded as a denial of the Socialist doctrine that the provision of work or maintenance and also the care of the people's health were direct obligations falling on the community as a whole." (11) They saw the contributory principles as both demeaning to the workers who were compelled to contribute, and as contradictory to an essentially social measure, by virtue of its being financed at the expense of the poor.

The trade unions, on the other hand, were relatively pleased with both parts of the National Insurance Act. Compulsory contributions to a state scheme (even if administered by existing agencies under the Act, as Approved Societies) would free some of their own funds for other purposes; the Act extended benefits to groups of workers who would probably have remained unprotected without state intervention; and the new Approved Society arrangement of collection and administration would mean a certain aggrandisement of function for the trade union benevolent fund machinery. They had, in short, several material reasons for favouring the particular form of the new insurance scheme even though some union interests at the same time opposed aspects of it.

In Parliament, therefore, the Labour Party was split between its trade union members, who favoured amendment and quick passage of the Bill, and a small socialist minority who maintained uncompromising opposition to it. The minority Liberal government had relied upon Labour support to pass the Bill, and had received it. But the negative features of the insurance scheme, apparent as they were to many Labour supporters, despite the tactical support they gave the Liberals in Parliament, marked the divergence of the Labour Party from Liberal social policy, which it had supported for several years. It opened a

political split within the Party, between the trade unions and socialists, over the nature of social reform, and fuelled a general questioning of the Party's commitment to socialism and political independence.

The Beginnings of the Socialist Medical Reform Movement

Reference has earlier been made to the founding of the State Medical Service Association on July 26, 1912. It is worth noting here that this occurred at what was perhaps the height of the British Medical Association's campaign against National Health Insurance, which had technically come into effect on July 15, 1912. Lloyd George was to wage a difficult battle with the British Medical Association until early 1913 for their acceptance of the plan, while the sustained opposition of the BMA leadership helped to promote several splits in the profession, including the formation of the State Medical Service Association. This organisation, on its inaugural meeting in July 1912, adopted a programme answering in many respects the 'six cardinal demands' which the BMA passed a year earlier. The socialist programme of the State Medical Service Association would have required:

1. The medical profession to be organised as in other State Services
2. Entry to the profession by one State examination
3. All members of the Service to be paid by salaries, which would reflect experience and seniority, with pensions
4. Free choice of doctor as far as possible, but specified maximum patient lists for doctors
5. Preventive as well as curative orientation; nationalisation of all hospitals; hospital use for all relevant procedures by referral of and in conjunction

with the patient's practitioner

6. Eligibility in the Service to all persons, regardless of age, income, health status, etc. (12)

Dr Benjamin Moore, one of the founders of the State Medical Service Association, had begun his campaign a year earlier in the pages of the BRITISH MEDICAL JOURNAL. (13) With the founding of the Association, the campaign became more widespread, particularly through pamphlets, meetings and articles concerning the advantages of a comprehensive health service. Dr Charles Parker, Secretary of the Association, publicised in 1912 a plan for a regionally organised system, with regional catchment areas of about 100,000 population around a district hospital, in which consultant practice and Medical Officers of Health would be based. General practitioners and some specialists would work at local 'receiving stations', well-equipped collective surgeries, clearly similar in concept to what were later termed 'health centres'. Dr Milson Rhodes in a 1912 pamphlet elaborated further this structure of a state scheme organised around district medical facilities, publicly owned and managed by local doctors; he did not recommend a fully salaried service. Discussions on the structure of an ideal state service were maintained by the Association through the First War. It also "discussed its relations with the rising Labour Party and continuously advocated the setting up of a Ministry of Health as a preliminary step to a National Medical Service." (14)

There were other breakaway movements from the unity of the BMA, occasioned more directly by its opposition to insurance. In its Special Representative Meeting, following an increased capitation fee offer by Lloyd George in late October 1912, a vote was taken on participation in the new scheme. Of the approximately one-half of the BMA membership who

voted, the majority were overwhelmingly opposed. The meeting recommended that doctors in each locality negotiate independently with insured persons, outside the specified local committees. The first significant break from the apparently united opposition was the refusal of fourteen prominent doctors, eminent consultants and private practitioners, to resign from the national insurance advisory body. In December 1912, led by this group, doctors willing to serve under the Act - despite BMA policy - formed the National Insurance Practitioners' Association, following a proposal by Dr Alfred Salter who was later to be Labour Member of Parliament for Bermondsey.

Lloyd George offered support to the new group in their effort to begin practice under the Act. The Association aided the establishment of the first insurance panel in Birmingham. By the beginning of January 1913, 10,000 doctors had defied BMA policy and registered with the Insurance Commissioners as willing to serve. By mid January, the BMA recognised that it had lost the confidence of a majority of doctors in opposing the Act, and another Special Representative Meeting voted to release them from their previous pledge of opposition to it. The public began immediately to join in large numbers, while BMA membership began a sharp decline. By 1917, the BMA's Insurance Act Committee was reporting near unanimous support of the Act among members -- a substantial number of members wanted extensions of both the portion of the population and of medical treatments covered by insurance. (15) Brand notes the important role played by those eminent dissenting members who felt their primary social responsibility was to practise under the Act, and the failure of the BMA to control its membership, as crucial in giving the victory to the government.

The Social Organisation of Health by 1913

Going into World War I, therefore, Britain had several major items of social legislation in operation, including National Health Insurance, with its limited coverage. The legislation was enacted by a Liberal government, under the apparently progressive impulse of Lloyd George, and with the Parliamentary assistance of the Labour Party. There was unanimity in recognising that the social risks addressed by the legislation should be lessened by action of the state, on society's behalf. There was less unanimity, indeed disagreement, about the principles upon which action should be based, and the agencies to be enlisted by the state (the artificially created 'Approved Societies' in the case of health insurance) to administer the scheme.

The medical profession, in the end, as satisfied with the insurance principle, having been protected from the previous evils of contract practice with insuring agencies by the compromise of the new local insurance committees. They were satisfied, too, with most of the other arrangements, including higher fees, security of tenure, free choice of participation, and the exclusion of middle class patients, who would have to continue to pay private fees. Titmuss notes that "compared with what had obtained before, the material rewards for most general practitioners were approximately doubled." (16)

The insurance companies and friendly societies were able to take advantage of participation in health and disability insurance while being able to preserve their traditional, private forms of insurance, including pensions and funeral benefits, no mean gain considering their profitability.

The trade unions, along with the non-profit friendly societies,

were happy with the 'Approved Society' arrangements. It allowed them to free substantial funds for other purposes and for member benefit schemes, some of course being the extra medical insurance benefits such as insurance for dental and optical treatment which the sufficiently wealthy Approved Societies were allowed to give their members. The unions thus became more attractive organisations to potential members.

It was left to socialist groups, therefore, and to some sectors within the Labour Party to object in principle to insurance (and very limited insurance at that) as a means of implementing society's new recognition of a responsibility to deal with individual sickness and its consequences. Lloyd George was on record, both before and after enactment of National Health Insurance, as preferring much extended forms of social and medical insurance, seeing his particular Act as only a "temporary expedient" on the way to provision for treatment for the entire family, increased sickness benefits, and pensions for widows, orphans and upon retirement. Indeed he had planned improvements in the 1914 budget and an inquiry into insurance which were interrupted by the War. While the BRITISH MEDICAL JOURNAL noted the lack of insurance coverage for diagnostic services, specialist treatment, nursing and hospital care, Brand remarks, the British Medical Association "had not seen fit to incorporate them in its 'cardinal points'"; rather its final battle which it lost, was in fact for the limitation of the plan to those earning only very low incomes. (17)

Sidney and Beatrice Webb maintained vocal opposition to the principle of insurance for limited medical treatment on the grounds that it did nothing to prevent individual ill health or even to extend the principles of past public health measures. The State Medical Service

Association, through its individual members' writing and publicising, and as a group, was developing and attempting to popularise detailed plans for a national health service available to all, based on restructured neighbourhood general practice and a new relationship between general and hospital practice. And the Labour Party, now separating itself from Liberal social reform, was also beginning to consider adopting a health service as party policy.

The Labour Party took such a position not only for philosophical reasons and because of pressure from socialists within, but also because the identification of social insurance as a Liberal policy was becoming a distinct political disadvantage to Labour. The Liberals had adopted and encouraged the popularisation of insurance for a variety of reasons. The actuarial principle suited their philosophy; and it was possible to employ the private insurance sector in administration. But, politically, according to Fraser:

in the longer term social insurance was deliberately used as a means of making socialism less likely. The National Insurance Act is sometimes hailed as a major step on the road to a socialist Britain, but just the opposite was intended. Lloyd George and Churchill were using that strategy propounded by Balfour at the 1895 election which would use social policy to head off socialism. Liberal collectivism was not to be a half-way house to socialism but its opposite ...

Insurance, by helping to provide that 'national minimum' of which the Webbs were always speaking, would make changes in the organisation of the whole society less likely. Indeed insurance was the capitalist's answer to the problem of want, and by reducing it, insurance covered up what the socialist saw as the root cause of poverty ... It was not just in the details but also in the underlying aims that the British insurance scheme was modelled on that of Bismarck. (18)

It would appear to be the case from fragmentary memoranda of Lloyd George, that he wished to transcend the "temporary expedient" of

insurance sooner rather than later by providing insurance not only for sickness but also for unemployment and poverty, honourably implemented by the state in recognition of its obligation to citizens in these matters. (19) The War was soon to intervene, however, and the insurance measures enacted before it were to remain in place until after the Second World War, coming under increasing scrutiny and criticism in the latter part of that period. Aspirations for political and social reform were to surge in the First War -- there were high expectations that 'reconstruction' would bring increased security, provided by the community.

The war helped to raise expectations in the practice of medicine -- in medical science, in which many advances were made -- and in social medicine. As Sigerist observes of Europe and the Soviet Union, "The war had demonstrated the importance of protecting the workers' health, and industrial medicine developed as never before." (20)

The Inter-War Period: A New Ministry of Health

Public aspiration for social change following the war merged with government fears of the development of revolutionary politics and with some far-sighted reform impulses in government. These were given recognition in the creation in 1919 of a Ministry of Reconstruction, under the reform-minded Dr Christopher Addison. Lloyd George took personal interest in the project of rebuilding the state's role in social relations and thus in the activities of the Reconstruction Ministry, which were to be mainly health, housing, education and unemployment insurance.

The condition of public health had been brought to public and

government attention during the war by the appalling health status of potential military recruits. The concern engendered by this along with concern for war casualties aided health reformers, including Dr Addison, in the drive to have a unified Ministry of Health established. It took him two years, however, to overcome the vested interests of the Poor Law Division of the Local Government Board (which feared the 1909 Minority Report being implemented, in effect, in their transfer to a central Ministry) and of the Approved Societies (which feared a takeover of maternity benefits by local authorities and the negative identification of insurance with the Poor Law). "In effect the new Ministry was a merging of the old Local Government Board with the Insurance Commissions and it meant that the Poor Law remained intact within the Ministry of Health. Though under immediate attack, the Poor Law was not to be remodelled until 1929." (21) The new Ministry of Health was responsible for another major policy undertaking, housing.

One of the first actions of the Minister, with respect to health, was to appoint Lord Dawson of Penn as chairman of the new Consultative Council to report on necessary health services, assuming a regional basis of organisation. The Council presented, with much urgency, an interim report in 1920 on the "Future Provisions of Medical and Allied Services." The now-famous Dawson Report noted the failure of existing services to make widely available the best medical knowledge and recommended the integration of preventive and curative medicine within the sphere of both individual general practice and specialist hospital practice. The two levels of practice could effectively be integrated by the establishment of two levels of 'health centre', primary, or neighbourhood-based for general practice, and secondary, or services for

tuberculosis, mental health, epilepsy, some infectious diseases, and orthopaedic treatment. (22) The emphasis was on providing the best quality care, and on careful, steady construction of the service.

Lord Dawson described facilities to be provided at primary and secondary levels in some detail. Perhaps the most well-remembered aspect of his Report is the plan for primary health centres, which would have integrated all primary health care including dental and ophthalmic and ambulance services, along with child welfare, prenatal, and home nursing care. A whole-time salaried service was not recommended, nor was the abolition of fees to patients. The latter was, however, advocated by a minority on the Consultative Council; the majority felt patients should contribute through insurance. The scheme was seen as a locally-organised one, with no position taken on the form of local administration or on the general question of relation to Poor Law medical services.

The recommendation of health centres by Dawson ironically caused something of a setback for the State Medical Service Association. D. Stark Murray reports that many in the Association felt their ten-year fight for reorganised health services was complete with the Dawson Report, and dropped out of activity. Others in the SMSA were critical of Dawson, finding the proposals for general and specialist practice ill thought out. They disagreed with the Dawson's rejection of salaried service, particularly in light of the success of salaried medical practice during the war. Nonetheless, apart from small, infrequent meetings the SMSA was nearly dormant until 1929, following the Dawson Report, and under the urgency of greater postwar social problems. Several of its prominent members remained active in an advisory

committee on health to the Labour Party. (23)

The Dawson Report of 1920 would appear not to deserve the present-day credit given to it for being the first statement on hospital regionalisation: the SMSA had advocated such a plan in 1912. Navarro sees the Report not as the pioneering and radical document it is frequently reported to be, but rather as essentially "a conservative document, produced by a Conservative-Liberal coalition as a reaction to a social movement -- the socialist labour movement -- that was perceived as a profound threat to the forces and constituencies that brought about and supported the report." This was especially so since the Labour Party, with a more radical platform advocating state action in health and social security, had risen to the largest opposition party in the 1918 election, with 22 percent of the vote. In its deference to the medical profession and private practice, and in its caution over reorganising medical services, referring to simple co-ordination rather than the regional 'integration' proposed by the SMSA, Navarro sees the Dawson Report as "the conservative rebuttal to the socialist [plan] for regionalisation." Hart too sees it as a temporary and rhetorical response to the radical tenor of the times, which were soon to change in the crushing depression of the 1920s. (24)

Meanwhile, the issue of restructured health services, including the possibility of a breakup of the Poor Law medical facilities, was in 1919 and 1920 a matter of Cabinet concern on several levels.

The breakup of the Poor Law services had been mooted in a draft Parliamentary bill presented by the Approved Societies to the Government in 1917, in the early negotiations for the founding of the Ministry of Health. This 1917 draft anticipated the Dawson recommendations of 1920

by suggesting the regionalisation of hospitals, but the Societies were extremely reluctant to give their approval to a new Ministry, except on their own terms, essentially, control over Poor Law services to be incorporated. (25) Those terms were unacceptable to the Poor Law administration. With the Ministry finally in existence after protracted negotiations between the Government and the insurance and Poor Law interests, Dr Addison as Minister was keen during his brief tenure to reform the Poor Law and reorganise its medical services. But the impetus for this major reform was to lose the support of the government by early 1921, when Addison was succeeded as Minister by Sir Alfred Mond.

In the context of a readjustment of the rate of medical benefit paid to doctors under National Health Insurance, a discussion was held by the Health Insurance Committee of Cabinet in late 1919, during which it was concluded that medical benefit was an inappropriate benefit in an insurance scheme, causing difficulties in actuarial calculation that were virtually impossible to translate into government policy. In this debate, it was accepted by the Cabinet that the problems of health insurance could not be resolved; they had the difficult option of an overhaul of health services, but did not take it.

Gilbert notes that this was "... one of the few Cabinet level reviews [the subject of national health insurance] would receive in the interwar period. Here the reconstruction of British medicine, and Addison's goal, the establishment of a separate medical service, were put off for a quarter century." It was clear at that time that the vested interests in support of the retention of the Poor Law, including the Approved Societies, were able to muster sufficient opposition to deter the Lloyd George government from trying to reconstruct medical

services, beyond establishing the new Ministry of Health, which had been difficult enough. Further, Gilbert comments:

... by 1920, the surge for reform had nearly run its course. The rebuilding of state medical and health activities might have been possible at the end of the war with thousands of doctors without established practices returning from the armed services, but such changes would have been incredibly expensive. With relentless City pressure upon the Cabinet for the reduction of the cost of housing and unemployment programmes, there was little chance of the expansion of any government activity which seemed to be working at least reasonably well. This is particularly true of a programme that was largely supported by the working-class beneficiaries themselves. The transfer of the burden of the medical benefit from national health insurance contributions to the income surtax payer would have caused a political explosion among the Government's backbenchers in the Coupon Parliament, who detested the Minister of Health and all his works and who were fighting with every weapon to have government expenditures and taxes reduced. (26)

Health Services Reform Debates in the 1920s

It was clear, therefore, that by the time Addison was replaced as Minister of Health in 1920 the forces aligned against major health reform, including the insurance organisations and financial interests of the City of London, had acted successfully. On the other side there existed a body of ideas and reformers, organised but not nearly as powerful, both within and outside Government. They had, by 1920, gone some way toward establishing detailed policy proposals addressed to the most evident problems of the Poor Law public medical services, the limitations of National Health Insurance, the disorganised hospital services, and the gulf between general and specialist practice. These views, in general and with varying emphases, were held across a wide political spectrum, from radical socialists to the Labour Party and

Fabian Society, to a number of prominent medical reformers, some within government. Although the political climate and austere economic circumstances of the 1920s were generally to prove barren for the enactment of health service reform, ideas did not cease to emerge.

The major policy recommendations of the Dawson Report died, but observations that the financial troubles and widely varied services of the voluntary hospitals should be investigated were acted upon. Viscount Cave was appointed to head a Committee in 1921 to examine the situation of voluntary hospitals. The Cave Report recommended a Hospitals Commission for Great Britain to co-ordinate their functions, and the administration of grants-in-aid through local Voluntary Hospitals Committees. (27) It might be noted that the Cave Committee was appointed following the defeat by the House of Lords of Addison's Ministry of Health (Miscellaneous Provisions) Bill of 1920, which would have given local authorities the power to take over Poor Law infirmaries, under permission or direction of the Minister, to be operated as municipal hospitals. Also, importantly, it would have permitted local authorities to subsidise voluntary hospitals which were then in a state of financial crisis. The Tories in Parliament objected to what they saw as both the beginnings of the municipalisation of voluntary hospitals, and an unwarranted increase in the powers of the Ministry. The Bill barely passed the House of Commons, was defeated in the House of Lords, and was soon dropped by Lloyd George. In this context, the Cave Committee was appointed in January, and Addison, by April 1921, resigned, his influence at an end. (28) With Sir Alfred Mond succeeding Addison as Minister of Health and Housing, the possibility of any radical restructuring of health services or Poor Law

functions was also at an end. Ministerial continuity itself ended temporarily. There were to be no fewer than six Ministers by the end of 1924. (29)

The recommendations of the Cave Committee, however, were taken seriously, resulting in the appointment of a Voluntary Hospitals Commission, with Local Voluntary Hospitals Committees, and a substantial grant made by Parliament. The financial and administrative condition of voluntary hospitals was further reported on, negatively, in 1923, by the Chairman of the Commission, Lord Onslow.

Ross reports the retrospective findings of the Sankey Commission in 1937 on voluntary hospitals. The co-ordination recommended by Cave had not been effectively carried out, the Local Committees having largely ceased to function. The voluntary hospitals had been in internal financial trouble in 1920 and through the 1920s, but it was not until the widespread creation of a competing municipal hospital system after the Local Government Act of 1929 (signalling the end of Poor Law institutions and their takeover by local authorities) that the voluntary system felt any great external threat. By 1937, therefore, the voluntary hospitals were demanding assistance in regional co-ordination and demarcation of their services, and more financial aid, for fear of being overtaken by the growing municipal hospital system. (30)

Medical benefit to doctors through the early 1920s had become the object of much heated political discussion, the capitation fee having been amended downward, and then raised following a Court of Inquiry in 1924. Only a few days earlier, the Baldwin Government had been defeated in the House of Commons, and it was up to the new Minister of Health in March to announce a capitation fee settlement and the appointment of a

Royal Commission on National Health Insurance, under Lord Lawrence. It had wide terms of reference, but a generally conservative group of Commissioners dominated by the private insurance industry, with no Approved Society representation. (31) The Commission conducted an extensive and well documented inquiry. It concluded that the insurance system was working efficiently, given its premises. It did note the problem of exclusion of dependants and limited benefits, and recommended correcting these by extending the coverage of the scheme to include dental, ophthalmic and some specialist treatments, but no inpatient hospital care. It suggested adding dependants' allowances to the sick benefits (which had been paid at a flat rate to the wage-earner regardless of family size). Since some Approved Societies were wealthier than others (many could not have afforded the extra benefits), the recommendation was that half of the Societies' surpluses be pooled in order to provide a uniform extension of new benefits. This was taken to be the most significant recommendation, since its implementation would mark the beginning of the end of the competitive Approved Society system. That very fact, of course, made pooling politically impossible, since the parent organisations of the Approved Societies, particularly the large insurance companies, guarded jealously their independence and profitable investment funds, which in large measure depended on the perpetuation of the Approved Society system. Indeed, that system itself came under heavy attack in evidence to the Commission, as a sham administrative compromise which worked vastly to enhance the profitability of the major private insurers.

A minority report of the Royal Commission, largely ignored at the time, criticised the linking of health insurance through Approved

Societies to major private companies. Gilbert notes that this report went far beyond the Labour Party's attack (in evidence to the Commission) on the power of insurance companies, in stating that health insurance as it was administered stood entirely in the way of a comprehensive national health policy. (32) Even the majority report concluded, significantly, that the ultimate solution for medical services would be to separate them entirely from insurance, as a public service, but it declined to take a position on how wide a public should be served, and how the service should be financed. (33)

The Royal Commission's majority and minority reports, despite their very moderate immediate policy recommendations, were not acted upon. However, immediately following their completion in February, 1926, the Conservative government under Baldwin began a squeeze on the Approved Societies by a further cut in government contributions to National Health Insurance, taken to be mainly a money-saving measure. The Government waited until 1928 to take any action on the Royal Commission's reports. Then, in the National Health Insurance Bill, it acted on none of the substantive recommendations for extension of coverage and benefits, but made only minor housekeeping changes. (34)

The end of the decade of the 1920s in public health marked the end of the Poor Law Boards of Guardians, under the provisions of the important Local Government Act of 1929. The Guardians were abolished and Poor Law medical services, particularly their extensive if poorly equipped hospital system, and maternity, child welfare, tuberculosis and other special facilities were handed over to the new, enlarged local authorities. It made possible a great rationalisation of public health facilities and their formal removal from Poor Law stigma. The new Act

gave local authorities wide discretionary powers. This fact, combined with the worsening economic situation after 1929, meant progress in developing new facilities was quite uneven. While it was mandatory for the new authorities to set up bodies to co-ordinate services between municipal and voluntary hospital sectors, these bodies, according to Eckstein, "had little more than a perfunctory life in the majority of cases. They had to cope with the formidable barriers of distrust and jealousy between the two hospital systems and generally restricted their activities to desultory meetings which satisfied the statutory requirement but little else." (35)

The 1930s: Steps Toward a National Medical Service

The decade of the 1930s saw initiatives taken by two of the main non-government interests involved in health services -- the British Medical Association and the British Hospitals Association, representing voluntary hospitals. These two associations published their views in major reports which became important documents in the planning process leading up to the National Health Service.

The British Medical Association published its first report, PROPOSALS FOR A GENERAL MEDICAL SERVICE FOR THE NATION, in 1930, and re-issued it in 1938 as A GENERAL MEDICAL SERVICE FOR THE NATION, along with a statement on Hospital Policy. Its scheme was based on the existing health insurance system, but it was recommended that coverage be extended to dependants of insured persons, and to others of like economic status. Covered services would include dental, ophthalmic and full maternity treatment. It further proposed regional administrative units for all public health services. Its Hospital Policy statement

recommended regional groupings, with close co-ordination among each region's voluntary and municipal hospitals, a landmark position recognising the growing influence of the newly organised municipal hospital system. Hospital treatment would not, however, be covered by compulsory insurance: rather, fees would be charged to patients, who would have the option of participating in various hospital contributory insurance schemes which were strongly favoured by the BMA, and expected to grow. Lindsey refers to the BMA report of 1938, and the more comprehensive INTERIM REPORT OF THE MEDICAL PLANNING COMMISSION of 1942, as ". . . classic examples of impartiality, constituting the high water mark of progressive thought for that organization." (36)

The voluntary hospitals after 1929 were coming under increasing pressure from financial constraints and the competition of the municipal hospitals. Their problematic situation prompted the British Hospitals Association, as their representative organisation, to appoint, in 1935, a Voluntary Hospitals Commission, under Lord Sankey, to consider measures which would protect their future. The Sankey Report, completed in 1937, included a detailed survey of the functioning of the voluntary hospitals. It recommended, most importantly, the creation of hospital regions and a structure of regional and central hospital councils to co-ordinate their services within and among regions. It proposed some representation for local authorities on behalf of the rival municipal hospitals, but had no suggestions for co-ordination within the municipal hospital system.

Although the BHA report expressed views in harmony with those of the British Medical Association, neither its minimal proposals nor those of the BMA for a voluntary scheme of co-ordination were acted upon by

the hospitals. It was to take the exigencies of war, and the Emergency Medical Service, to begin any kind of regional reorganisation of voluntary hospitals. This was followed during the war by the now-famous Hospital Surveys, detailed government-sponsored inventories of all hospitals, which became the basis for the regionalisation attained by the National Health Service. Eckstein notes that "By 1944 ... the view that the hospitals should be regionalized under some sort of effective authority had become orthodox doctrine. The only major point still debated centered on the role which the voluntary hospitals would play in the hospital regions; in brief, whether it was worth preserving the system or not." (37)

The final major report of the 1930s was the Political and Economic Planning SURVEY OF THE BRITISH HEALTH SERVICES, issued in 1937. (38) PEP, as an independent, non-political group of expert social and economic analysts, had been publishing "broadsheets" based on extensive research, since its founding in 1931. In 1937 it published major reports on both social services and health services in Britain. The latter was summarised in a popular edition, BRITAIN'S HEALTH, edited by S. M. Herbert, published in 1939, which became a best-seller, (39) ample indication of the growing public interest by that time in reform of the health services.

The PEP Report emphasised the quality of health of the population as the primary matter for concern in any overall approach to health services. Breakdowns in personal health as a result of poverty, insecurity, lack of health education, bad housing and working conditions, lack of recreation and other such factors became in the last analysis the responsibility and the burden of the medical services. As

long as adverse economic and environmental conditions existed, health services, despite their best prevention and curative efforts, could not possibly be expected to restore a population to health if only because of an excessively large patient load.

With respect to reforms in the existing medical system, PEP stressed co-ordination, from general practitioner through hospital and environmental services, all under regional authorities with representatives from each service.

But it recommended proceeding gradually with expansion, implementing the extension of services in stages (a position which PEP was soon to change), and did not propose an entirely public service. One of the first stages of reform would have extended national health insurance for general practitioner care to dependents. Other changes were to come later.

While its recommendations were not radical in comparison with the earlier mentioned reports, the detailed analysis of the PEP Report was perhaps more significant in aiding informed public discussion of the state of existing services and their accessibility, and the state of the public's health as related to economic and social factors. Coming when it did, on the eve of war, it became both a natural source of documentary evidence and a guide to the discussion of issues and of principles for constructing a new medical service.

The Socialist Case for a State Health Service

The State Medical Service Association, which had spent the latter part of the 1920s in relative dormancy, was ready for rebirth. In 1929, after much debate about the political role of the SMSA with respect to

the Labour Party, in which several SMSA members had been active in the Public Health Advisory Committee, the majority view prevailed and it became a 'non-party' group under the name National Medical Service Association. As such its policy advocated:

1. A free National Medical Service available to all members of the community and providing every form of medical, surgical, obstetrical, dental, and preventive treatment
2. The provision of necessary institutional treatment, consultant and specialist services including bacteriological, pathological and X-ray, together with all known means for the treatment and prevention of disease
3. All to be co-ordinated in one service by the Ministry of Health (40)

While there was unanimous agreement on these principles, D. Stark Murray notes, there was growing disagreement on the political means of attaining them. A good deal of opinion in the Association favoured gradual implementation, in stages, beginning with an extension of health insurance to dependents, but taking insurance out of the hands of the Approved Societies, and giving the whole scheme to the Ministry of Health and local authorities. This was, reports Murray, the view at that time of the Public Health Advisory Committee of the Labour Party. The other viewpoint opposed insurance, and favoured an immediate move to a full-scale health service not yet defined in detail.

These political differences were to result in the National Medical Service Association being overtaken in 1930 by the newly founded Socialist Medical Association (SMA). Mr Somerville Hastings, Labour MP for Reading, who had left the older Association and was nominated the first President of the SMA, was committed to an integrated and co-ordinated service, preventively oriented, stressing medical teamwork

to back up the role of the general practitioner, and operating from health centres, which would house the various health practitioners and services, including, where appropriate, an industrial health service. A new notion was that of the hospital-based specialist visiting patients' homes, where necessary, in consultation with their family doctors.

The SMA was unanimous in its political commitment to socialism and to pursuing the goal of a health service as an affiliate organisation of the Labour Party. Its founding principles were:

1. To work for a Socialised Medical Service both preventive and curative, free and open to all
2. To secure for the people the highest possible standard of health
3. To disseminate the principles of Socialism within the medical and allied services

The first Executive Committee of the SMA included, among others, two Members of Parliament, both doctors, and, indicating a close relationship between the SMA and a fraternal medical organisation, Dr Alfred Welply, General Secretary of the Medical Practitioners' Union.

By the end of 1930, the Executive Committee had given its new Research Sub-Committee the task of drawing up in detail "practical measures for a Free Socialised Medical Service." Even the British Medical Association, among other groups, responded to an invitation to submit views to the Sub-Committee. (41)

In 1931 the SMA prepared a "Health Policy for London" which was later to become the basis for London County Council policy. Somerville Hastings was influential for many years as Chairman of the LCC Public Health Committee.

The SMA made its first major contribution to Labour Party national health policy at the 1932 Labour Party Conference, which passed a

general resolution calling for the establishment of a State Medical Service. Murray reports that there were some doubts among a minority of SMA members in 1932 over the appropriateness of calling for a complete health service. Some still favoured the more conservative course of the initial extension of health insurance to be followed later with a regionalised hospital service. This was an argument which was to be repeated outside the SMA, particularly by the BMA, up to the founding of the Health Service. A further minority view stressed democratic control by the workers in the various parts of the service.

A more elaborate policy statement on a 'National Health Service', prepared mainly by the SMA, was passed unanimously by the 1934 Labour Party Conference. At the same time, the Party issued a discussion document by Somerville Hastings, again proposing that all services be grouped within regional health authorities, based when possible on reorganised local government but until then on the county system. It also presented a detailed proposal for Health Centres, and for group laboratories. In 1934 the SMA issued a proposal for a national maternity service, having sponsored extensive debates on maternal health and on the relative merits of home midwifery and hospital maternity services.

The Labour Party took advantage in the 1935 general election of its new policy for a National Health Service, and of the affiliation of the SMA; ten SMA members were Labour candidates. Included among these was Dr Christopher Addison, the first Health Minister. Only one of the SMA members was elected -- Dr Alfred Salter MP, who was re-elected. As has been noted by Dr Stark Murray, the SMA was already having considerable influence on London County Council health policy through the Labour majority elected in 1934.

In 1936 the Voluntary Hospitals Commission accepted views submitted by the SMA on several particular aspects of hospital policy, including centralised regional procedures for emergency admissions, convalescent hospitals, and outpatient arrangements. (42)

The Socialist Medical Association oriented itself toward the public, the profession, international politics, and toward its base of operation, the Labour Party, in the years preceding World War II. Internationally, it was aiding refugees of Nazism, and through the Spanish Medical Aid Committee it sent volunteers and equipment to the aid of the Republican side in Spain. Its role in the Labour Party and in the London County Council have been noted. Its public presence was as an educational group, promoting discussion of the future of Britain's health services through organising meetings, and through its journal, *MEDICINE TODAY AND TOMORROW*. Although most of its leading members were medical professionals, it was open to all health workers, and in fact had the active contributions of a wide variety of both medical specialists and members of other health-related professions and occupations. Though not a large organisation, it appears to have had a disproportionately large influence on the progress of ideas. With its philosophy, the promotion of a concept of health linked with its vision of a democratic, socialist society, and as the leading edge of the Labour Party in medical-political matters, the SMA was to become the ideological opponent of the British Medical Association and the British Hospitals Association in the war years, during which time the National Health Service took shape.

The Social Organisation of Health Before World War II

By the end of the 1930s, therefore, there had been a considerable clarification of opposing and conflicting models of reform of the organisation of health care. The continuum of ideological positions was virtually complete, the interests were beginning to organise, with the expectation that the state was about to be obliged to make major changes in the existing system.

On the one side were grouped those interests who favoured retention of National Health Insurance, with expanded coverage. The BMA was in favour of a regionally co-ordinated health service, based on insurance, and on the inviolable independence of the doctor, but the Association was far from united internally. The BHA, concerned for the financial viability of the voluntary hospitals, and of specialist practice within them, supported extended insurance and state subsidies, but was extremely fearful of administrative co-ordination with the municipal hospital system. The Approved Societies, whether related to the friendly societies or commercial insurance companies, took a proprietary interest in National Health Insurance, which was an extremely profitable branch of their operations; but their financial allies of the City of London opposed any large-scale extensions of state expenditure which would, of course, have to be raised through taxes.

On the other side were the as yet not well organised forces advocating a state health service, which had little direct influence on the government. The SMA, having regrouped in 1930 to advocate a state health service the features of which, and its guiding definition of health, would reflect its socialist philosophy, was having an increasing influence on Labour Party policy. The TUC, and its member unions in the

health services, were not yet active participants; the unions themselves still had some ambivalence based upon the lucrative involvement of their friendly societies in health insurance administration, but clearly wished at least extension of coverage against illness, disability, and loss of earning capacity.

In the centre of the spectrum of health service models was that proposed by PEP, an ostensibly "disinterested" body, which informed debate on the health services enormously through its well-documented reporting on the multiple crises of the existing system, and its clear definition of issues and alternatives. While PEP originally advocated an extended insurance scheme, it was soon to re-evaluate this position in the light of its own analysis of the shortcomings of insurance. The views of PEP, which were shared by other reformers, including some progressives of the medical professions, spoke perhaps most directly to senior planners of the Ministry of Health, then cognisant on the eve of war that a vast reorganisation of services would be necessary.

The Ministry of Health, only two decades old in 1939, and charged with dealing with the chaotic division of jurisdictions, the two hospital systems, the Approved Societies, and the powerful medical profession, was to be the formulator of new state policy in health. Two decades' of investigations of health services and insurance had made clear the depth of problems to be overcome if a scheme were to be designed to serve the national interest fully. The balance of class forces was clearly changing: Titmuss points out that the burgeoning middle classes, excluded from National Health Insurance, were now demanding the fruits of modern scientific medicine without financial insecurity, as a matter of right; the anomalies and exclusions of the

old scheme were clearly a source of discontent for the working class.

Not all the political forces were aligned in 1939 as they were to be by the middle of the war, but it was clear that the state must take drastic action according to a new definition of the "national interest," in which the traditionally powerful sectional interests of private insurance, private hospitals, and organised medicine must be compromised and the middle and working classes must benefit significantly.

The emergency conditions of war were to add further clarity to the alternatives for the state, and further strength to the realignment and representation of interests in the state planning processes, as we shall see in the following chapter.

CHAPTER 2 -- FOOTNOTES

1. Jeanne L. Brand, *DOCTORS AND THE STATE: THE BRITISH MEDICAL PROFESSION AND GOVERNMENT ACTION IN PUBLIC HEALTH, 1870-1912* (Baltimore: The Johns Hopkins Press, 1965), pp. 4-5, 19, 154, 160.
2. Beatrice Webb had participated in the Royal Commission on the Poor Laws (1905-1909) and was principal author of the Minority Report of the Commission; with Sidney Webb she co-authored *THE STATE AND THE DOCTOR* (London: Longmans, Green and Co., 1910).
3. Brand, pp. 169-170, 200. These Fabian documents were: B. L. Hutchins, "What a Health Committee Can Do," Fabian Society Tract (London: 1908); and F. Lawson Dodd, "A National Medical Society," Fabian Society Tract (London: 1911). Perhaps the first use of the term 'National Health Service' was made by Dr Benjamin Moore in *THE DAWN OF THE HEALTH AGE* (1910). Moore went much beyond the recommendations of the Minority Report of the Royal Commission on the Poor Laws in urging a comprehensive state medical service, preventive and curative, in which all doctors would be salaried, and specialist services co-ordinated, and an occupational health service, with rigorous powers of enforcement, included; D. Stark Murray, *WHY A NATIONAL HEALTH SERVICE* (London: Pemberton Books, 1971), pp. 6-7.
4. Maurice Bruce, *THE COMING OF THE WELFARE STATE* (London: B. T. Batsford, 1961), Ch. 5, and p. 96.
5. G. D. H. Cole, *A SHORT HISTORY OF THE BRITISH WORKING CLASS MOVEMENT 1789-1947* (London: George Allen and Unwin, 1948), p. 307.
6. Bruce, pp. 210-215; Brand, p. 216; M. J. Lynch and S. S. Raphael, *MEDICINE AND THE STATE* (Springfield, USA: Charles C. Thomas, 1963), p. 119.
7. Brand, p. 216.
8. Harry Eckstein, *THE ENGLISH HEALTH SERVICE* (Cambridge, Mass.: Harvard University Press, 1958), p. 21.
9. See Bruce, pp. 216-217, for a discussion of the role of private insurance interests, and pp. 217-220 regarding the difficulties of the Act in Parliament.
10. Sir Henry N. Bunbury, ed., *LLOYD GEORGE'S AMBULANCE WAGON, BEING THE MEMOIRS OF WILLIAM J. BRAITHWAITE, 1911-1912* (London: Methuen, 1957), p. 115, as quoted in Brand, p. 213.
11. Cole, p. 309.

12. Murray, p. 8.
13. Brand, p. 217.
14. Murray, p. 12.
15. Brand, pp. 227-230.
16. Richard Titmuss, COMMITMENT TO WELFARE (London: George Allen and Unwin, 1971), p. 237.
17. Bruce, pp. 219-220; Brand, pp. 229-230.
18. Derek Fraser, THE EVOLUTION OF THE BRITISH WELFARE STATE (London: Macmillan, 1973), pp. 151-152.
19. Ibid., p. 157.
20. Henry E. Sigerist, "War and Medicine", in M. I. Roemer, ed., HENRY E. SIGERIST ON THE SOCIOLOGY OF MEDICINE (New York: M.D. Publications, 1960), p. 346.
21. Fraser, p. 167.
22. James Sterling Ross, THE NATIONAL HEALTH SERVICE IN GREAT BRITAIN (London: Oxford University Press, 1952), p. 51.
23. Murray, p. 15.
24. Vicente Navarro, CLASS STRUGGLE, THE STATE AND MEDICINE (London: Martin Robertson, 1978), pp. 16-19; J. Tudor Hart, "Reform and Reaction in Medical Care," INTERNATIONAL JOURNAL OF HEALTH SERVICES 2 (1972): 571.
25. Bentley B. Gilbert, BRITISH SOCIAL POLICY 1914-1939 (Ithaca, New York: Cornell University Press, 1970), pp. 114-118. Chapter 3 discusses in detail the difficulties in founding the Ministry.
26. Ibid., pp. 134-135, 151-155, 268-270.
27. Ross, p. 52.
28. Gilbert, p. 136.
29. Bruce, p. 244.
30. Ross, p. 53.
31. Gilbert, pp. 275-276.
32. Ibid., p. 281.
33. Ross, p. 54.

34. Gilbert, p. 283.
35. Eckstein, p. 111.
36. Almont Lindsey, SOCIALIZED MEDICINE IN ENGLAND AND WALES: THE NATIONAL HEALTH SERVICE 1948-1961 (Chapel Hill: The University of North Carolina Press, 1962), p. 26.
37. Eckstein, p. 113.
38. THE BRITISH HEALTH SERVICES (London: Political and Economic Planning, 1937).
39. S. Mervyn Herbert, BRITAIN'S HEALTH (London: Penguin Books, 1939).
40. Murray, p. 16.
41. Ibid., pp. 17, 21, 24. Murray does not report the content of the BMA submission, nor how it was received.
42. Ibid., pp. 25-26, 30.
43. Titmuss, COMMITMENT TO WELFARE, pp. 239-241.

CHAPTER 3

HEALTH SERVICES IN WAR AND RECONSTRUCTION

The campaign for state health services had undergone some changes in composition and direction during the interwar period. The earlier constellation of forces from the late nineteenth century to the advent of insurance, that is, the alliance of medical reformers in the public health field with likeminded government officials and with political campaigners such as the Webbs and the Fabian Society, had given way to reduced initiative from government and an increase in activity outside government by political groups. There was, for example, the new alliance of the Fabian Society and Labour Party, with the additional stimulus and expertise of the Socialist Medical Association.

The several Reports and Commissions of the 1930s highlighted the weaknesses of health insurance and the disparate array of medical services, while at the same time recording the views of the major interests and stimulating discussion among the public, the medical community, the trade unions and political parties.

But to a large extent it took war preparations and contingencies to confront the structural limitations of the old patchwork of health care and of social security provisions, and stimulate thinking along the lines of fundamentally restructuring services.

This became part of the vast task of reconstruction, of rebuilding and re-designing those social and economic arrangements which before and during the war had been antithetical to the health, security and productivity of the national community. Class relations had been

thoroughly strained through the twenties and thirties, and the government remembered well the political radicalisation that had taken place following the First World War, when the general expectation for a more secure and prosperous society, exemplified in the demand for 'Homes for Heroes', was not met.

Thus reconstruction planning during the Second War was undertaken earlier, with more urgency and with the increasing knowledge that social expectations were becoming irresistible, except at the peril of mass radicalisation on the scale of that following the First War. It was clear also to the government, and to the social policy analysts of Political and Economic Planning, among others, that improved social security and economic opportunity would further post-war industrial productivity and the nation's peacetime economic life; that was certainly one of the lessons of managing the wartime economy.

From the beginning of the war, then, three aspects of Britain's health services were to come under intense scrutiny: the quality and distribution of medical services, the arrangements for payment, and the differential accessibility of public and private health care to various social classes and groups. These, of course, were not new issues.

Uppermost among matters for debate was the disparate nature of existing health services. The patchy, unco-ordinated and often very poor quality of services was brought to light especially during the course of planning the wartime Emergency Medical Service.

Accomplishments of the Emergency Medical Service

Arrangements for the Emergency Medical Service were begun as early as 1938, following the Munich crisis, when the Ministry of Health

launched a survey of the nation's hospital capacity, with a view to arranging special priority medical treatment for war casualties. This would involve the establishment of twelve regions, within which hospital services and specialties could be co-ordinated among voluntary and municipal hospitals, and special blocks of beds reserved, their maintenance subsidised by the government, for expected air-raid casualties. Free treatment under the Emergency Medical Service was at first reserved for civilian and military casualties, but through the course of the war was extended to several categories of war workers, to evacuees who had been eligible for free public treatment in their home local authority but were not in their new locality, and to a wide miscellany of cases. The very matter of eligibility for free treatment was extremely complex, because of the multitude of local public, voluntary, private and insured arrangements in existence before the war. It took, for example, a sixty-two page official circular to specify cases eligible under the emergency scheme. (1)

The hospital surveys began in 1938 with a complete absence of statistical data, since no reporting system had existed for hospital capacities, services, catchment areas, admission policies, or finances. The Nuffield Provincial Hospitals Trust joined the Ministry in carrying out extensive regional surveys which were published in 1945. (2) The investigative part of the surveys uncovered, perhaps even more than any of the preceding government and commission reports, the chaos existing in hospital services, more so because of the necessity of placing all the nation's facilities in the context of one national system, for emergency services. Only a few of the overwhelming problems will be discussed here, as they are examined in detail elsewhere. (3)

The surveys covered both voluntary and municipal hospitals. They confirmed that the voluntary hospitals had the best medical staffs, particularly specialists, who were largely self-financing through lucrative private practices outside the hospitals. Voluntary hospitals were able to choose their patients, generally preferring those who were medically interesting or likely to be short-stay, while public hospitals were obliged to take anyone entitled, therefore became crowded with long-stay cases. Geographical distribution of beds in both hospital systems was most unequal, as was the distribution of general practitioners throughout the country. (4)

Perhaps more glaring than the problems of distribution were those of disorganisation and inefficient competition among hospitals. The competition stemmed from the historical foundations of each system, the one representing a type of elitist medical philanthropy, the other deriving from the Poor Law. It resulted in wasteful duplication and overlapping of specialist services, with frequently no co-ordination attempted. The municipal hospitals were subject to local authority boundaries in their catchment areas, which often made for unreasonable exclusion of patients in areas where no informal sharing arrangement existed. The systems suffered lack of co-ordination as much within as between them.

Both hospital systems were desperate for funds. Municipal hospitals were often little-improved from their original workhouse condition. Many had been transferred to the local authorities from Poor Law administration by permissive provision of the Local Government Act of 1929, and many local authorities had indeed planned large capital improvements as part of their new responsibilities, but these were

curtailed by the economies of the Depression years, followed by war.

The voluntary hospitals had relied on fees, collections, contributory schemes and larger philanthropic donations. As their expenses went up dramatically following the First World War, however, their voluntary income remained virtually the same. They thus came to rely on fees and grants from public funds: "By 1947, public authorities supplied more than half of the total income, or more than it had cost to run the entire system in 1935. From a financial standpoint, therefore, the voluntary hospitals were losing their voluntary character long before the Labour Government altered their legal status." (5) Eckstein comments further that the financial desperation of the voluntary hospitals had forced many to neglect maintenance, expansion and modernisation before 1946, which later had serious consequences for the NHS since some of the most important institutions for the new service were voluntary hospitals.

Several structural deficiencies therefore confronted the Emergency Medical Service planners in their efforts to create, at the very least, efficient and co-ordinated services to serve the worst medical emergencies of war. The major problems included badly funded and poorly equipped facilities, inequitable geographical distribution and near absence of efficient co-ordination among services, shortages of all types of manpower and of beds, discrepancies in availability of services, discrepancies of eligibility of the public to use them from one area to another, and irrational competition among hospitals. Finally, pervading the entire system, were all the shadings, glaring and subtle, of social class differences in access to certain facilities, payment methods, and quality of treatment. (6)

Planning by the Ministry of Health proceeded energetically and decisively. It was decided that the problems in the two hospital systems would have to be treated as irrelevant to the creation of a workable, regionalised emergency scheme:

Thus, from the outset of the planning process, all the crucial factors which defined the very nature of the institutional medical system were found to be either obstructive or irrelevant to the satisfaction of actual medical needs: the division of the system into voluntary and public institutions, the use of the latter strictly within local government boundaries, the differences between the two systems in staff and amenities, and the mushroom-growths of specialised institutions.

Unfortunately the very factors which made the existing institutional pattern inadequate also made it difficult to reorganize along rational lines. (7)

The Ministry set a goal of 300,000 beds to be allocated to the Emergency Scheme across Britain. This would be done by surveying and classifying all hospitals, grouping them in regions, determining the special role and particular emergency bed allocation for each hospital and planning for the co-ordination of functions of all hospitals in each region. Patients were to be over-crowded in some wards, or transferred to other institutions, in order to create free wings and wards for emergency use. Extra accommodation would be provided in tents, huddled annexes and other public and private buildings. Standards for quality of service and equipment for all hospitals would be achieved by upgrading and re-supplying operating suites, X-ray rooms, laboratories, dispensaries, medical and surgical supplies and the like.

By mid-1938 regional boundaries had been determined, regional administrations appointed, and all hospitals classified and graded into eight categories. (8) In 1939 the grouping and upgrading was carried out. Grouping was done on the principle of chains of hospitals. For

example, ten radial sectors were drawn from the London metropolitan area, functions being assigned to each hospital on a continuum, from acute reception units in the city centre, to evacuation and rehabilitation facilities in outlying areas. The grouping was done without regard to the status (voluntary or public) of the hospitals. For London, the inner-city hospitals were affiliated with each other between sectors and with the outlying hospitals in each sector. The central teaching hospitals were the key facility in each sector. The London region was administered directly by the Ministry of Health. The process of grouping was slowed by the suspicions of the voluntary hospitals of the Ministry's intentions, by their fears of loss of independence, their mutual jealousies and by compensation arrangements for participation.

To supplement this hospital scheme, both laboratory and blood transfusion services were organised, and continued under the NHS.

Salaries for medical manpower posed additional difficulties. While payment arrangements for municipal hospital staffs posed few problems, since they were already on full-time salary, the same was not the case for specialists in voluntary hospitals, who were honorary and part-time employees deriving their income from private practice outside the hospitals. The Ministry negotiated with the representative groups for specialists and arrived originally at a grading and salary scale for a full-time salaried medical corps to serve in the emergency scheme. The unpopularity of this arrangement among doctors prompted the Ministry to change to part-time salaried appointments along with other modifications in the emergency scheme implemented in 1939. The assignment of doctors to the emergency service, as well as their recruitment to the armed forces, led to a serious shortage in civilian medical services, which

continued to exist apart from the superimposed emergency scheme.

The very distinctness of the Emergency Medical Service from ordinary civilian services, while it did much to impose order on a chaotic structure, served in many ways to emphasise and exacerbate the contrasts between a state-organised, relatively efficient service and the underlying inefficiency of the plethora of disorganised services upon which it was superimposed. In the case of the voluntary hospitals, for example, Eckstein notes that it was to their advantage to reserve their quotas of beds for the emergency service and to be paid for doing so, but as far as possible to keep their regular beds empty to reduce expenses; this they did by unduly restrictive admission policies. The municipal hospitals, on the other hand, became even more than before dumping-places for the chronically ill, having no power to refuse admission. (9) The problem was particularly serious in London, where London County Council hospitals were virtually full with their previous caseloads of the chronically ill, plus the many civilian rejects of the voluntary hospitals.

The financial desperation of the voluntary hospitals was by this time more than apparent. The Ministry was paying a high proportion of their costs; many of them were severely damaged by bombing and had clearly insufficient resources of their own for rebuilding. Thus, in the face of the increasing contradictions between the two systems, and the increasing dependence of the voluntary institutions on the Ministry for their maintenance and very existence, it was clear that the crisis of war had thrust an irrevocable responsibility upon the Ministry of Health, in the form of a financially unsound collection of privately owned and managed hospitals bent on maintaining every vestige of

independence possible.

Many lessons were learned and precedents established through the building of the Emergency Medical Service. It had been conceived originally as a temporary, state-organised service for the war-injured, parallel to pre-existing services; it was not seen as a replacement for the old system. It soon became clear that the civilian sick, especially the chronically ill, were suffering neglect because of the emergency system and that eligibility for treatment by the emergency service had to be extended beyond war casualties. It was, accordingly, extended by new sets of regulations to more and more categories of patients, especially to evacuees, who would otherwise be ineligible for treatment outside their home area. By 1942 the attitude of the government toward its responsibilities in the area of hospitals had changed very much from 1939, and many of the practical foundations for a national scheme already existed in the emergency service.

The First Announcement of Postwar Policy

This change was given recognition in October, 1941, when the Minister of Health and the Secretary of State for Scotland announced in the House of Commons a policy for the future of the hospital services. That policy would be, as soon as possible after the war, to ensure by means of a comprehensive national hospital service, that appropriate treatment would be readily available to every person in need of it. (10) This marked the beginning of the extensive surveys undertaken for the government by the Nuffield Provincial Hospitals Trust, which were to be the basis for the comprehensive postwar hospital service. No policy on eventual hospital ownership had been arrived at in 1941; the role of the

voluntary hospitals was vigorously debated until it was resolved in the 1946 NHS Act, with the British Hospitals Association acting as staunch defender of their independence and most of the proponents of a National Health Service advocating merging the two systems under public authority.

There is no doubt that the medical profession and hospital interests were, even early in the war, suspicious that the Emergency Medical Service might threaten their autonomy. Lynch and Raphael report a reassurance by the Presidents of the Royal Colleges to readers of the BRITISH MEDICAL JOURNAL:

'There is suspicion amongst some doctors that the Ministry of Health may be proposing to use the EMS as a thin edge of the wedge for a post-war State Medical Service. We can assure such, on the highest authority, that nothing is further from the Ministry's intention and that all such fears are groundless. It may well be of course that after the war, economic conditions may make some form of assistance to the voluntary hospitals, by grants in aid or otherwise, necessary, but the voluntary system will continue, there is no reason to doubt.' (12)

The practical gains toward a comprehensive service made during the war were, according to Eckstein, relatively small, but the shift in expectations was enormous:

The system was not greatly changed. Rather, the war experience produced a general feeling that it would have to be radically altered afterwards, in the calmer atmosphere of peace. This is a point of very great significance: the first serious deliberate attempt to provide an effective institutional system quickly produced overwhelming sentiment for a large-scale public reorganizing of the existing services. (11)

It might be added that not only did sentiment develop, but a great deal of practical experience and knowledge was accumulated, especially in the Ministry of Health, with regard to the administration of

comprehensive, co-ordinated health services. The idea was legitimised and alternative methods of organisation were explored and evaluated. (13)

Perhaps the most important factor about the EMS as a step on the way to NHS was the inevitable contrast it established with the non-emergency, civilian health services. Indeed the latter suffered, and many civilian patients in categories not included under EMS provisions endured much hardship and inconvenience, due to the shift of resources to the emergency scheme, despite the two 'systems' existing side by side in the same institutions. (14)

Titmuss comments on the change of outlook with respect to collective provision of health and social services brought about by the struggle of war:

In many ways it was fortunate for the nation that this revision of ideas and rearrangement of values came so early in the war. They allowed and quickly encouraged great extensions to the social services; they helped many of these services to escape from the tradition of the poor laws, and they made them more acceptable to more people. The fact that the area of collective responsibility moved out so soon in a wider circle, drawing in more people and broadening the obligations to protect those in need, was to serve the nation well during the following five years of strain and deprivation. (15)

These new values and corresponding state services established irrevocable precedents. The EMS had provided treatment, in an efficient and co-ordinated service, as of right for war casualties, albeit not without restrictions to the rest of the population. But it had done so without regard to means or to insurance status; it had brought the two rival hospital systems at least partially into one; and it had enrolled a large number of practitioners and specialists in a salaried state

medical service.

These were developments which, but for the exigencies of war, would probably have remained the unfulfilled ideas of reformers. In effect, they were now to provide in practical terms a starting point for NHS planning. The mid-war reconstruction debate, from about 1941 to 1944, was also to prove extremely influential in legitimising state activity in health services provision, among other areas, and in giving further opportunity to socialist and other proponents of a National Health Service to make their points.

The Coalition government was formed in May 1940. Conscious of the social and economic problems caused by the mismanagement of reconstruction after World War I, it was determined to be seen to be serving broadly national interests, this time including those of labour. The Labour Party as a partner in the Coalition was concerned to implement social policies it had been advancing since long before the war. In this it had some success, holding several important Ministries, including the Ministry of Labour, under Ernest Bevin. Arthur Greenwood, experienced in reconstruction plans in World War I and a former Labour Minister of Health (1929-31), was appointed Minister Without Portfolio and Chairman of the Cabinet Committee on Reconstruction Problems.

The Beveridge Report

Greenwood, in June 1941, responded to a Trades Union Congress lobby against the inadequacy of existing health insurance provisions, with the appointment of a committee of inquiry with broad terms of reference. This was the Interdepartmental Committee on Social Insurance and Allied Services chaired by the Liberal reformer Sir William Beveridge.

The Beveridge Committee took evidence from a large number of organisations, between January and October 1942. Having personally formulated and presented the basic framework of his scheme early in 1942, Beveridge was obliged to take full personal responsibility for the Report, which was published in December 1942. (16) According to Calder, however, "the civil service experts who advised him generally sympathized with his ideas," (17) just as it was clear that many trade unions, employers' organisations, academic and political groups were in agreement with the fundamental principle of eliminating loss of earning power and insecurity through much more comprehensive social insurance.

The important portion of the Beveridge Report with respect to health services is the famous Assumption B, that a comprehensive health and rehabilitation service should be arranged by the state as one of three prerequisites of a social insurance scheme. (The others were children's allowances, and a policy of maintenance of full employment.) Upon these assumptions would rest a comprehensive social security scheme, with flat-rate contributions and subsistence benefits to cover sickness, medical, unemployment, widows', orphans', old age, maternity, industrial injury and funeral benefits. It would in effect rationalise existing schemes, closing gaps, centralising administration, widening eligibility and benefits. The purpose was, in Beveridge's terms, the positive one of providing freedom from the 'five giants': want, disease, ignorance, squalor and idleness. In this lay the relevance of the Report to the social policy of reconstruction, and the basis of its vast and immediate popularity. Beveridge had invited as much publicity for his recommendations as he could get, even before the publication of the Report, and near-universal awareness and popularity were the result.

While the Beveridge scheme was radical in the sense of proposing a social policy attack on deprivation and insecurity, the method proposed -- flat-rate contributory insurance rather than a redistributive tax supported plan -- was not. But because of the unfortunate association of Poor Law relief and medical services with a means-tested tax-supported scheme, Beveridge preferred benefits earned as of right through contribution. Fraser observes: "Culturally conditioned by capitalism to respect contract, British society resented means-tested relief which penalised thrift and impaired personal dignity, while respecting benefits of contractual entitlement. History and social psychology dictated that insurance, in Beveridge's phrase, 'is what the people of Britain desire'." (18) He notes that it was the universalism of the Beveridge proposals, especially in the context of wartime social solidarity, which made them most popular -- everyone, irrespective of wealth, would contribute equally and benefit equally. This of course made the scheme a regressive tax upon low income earners who would in addition not be subsidised with higher benefits. But politically, it was the principle of universality of contribution and equality of entitlement which made the recommendations so immediately popular. This was, even at the time, but especially in relation to the values of post-war Britain, something of an anachronism; later, equal subsistence-level benefits were gradually to be rejected in favour of earnings-related, tax-supported schemes.

Benefits under the proposed health service would be provided under the same universal principles as the rest of the social insurance scheme. The health service itself would be comprehensive, maintained by the Ministry of Health and paid, at least in part, from the general

social insurance contributions collected by the Ministry of Social Security. Its primary purpose in relation to social security would be as far as possible to ensure the positive health and wellbeing, particularly the productive capacity, of the population. By doing so, the financial burden of ill-health, loss of earning power and productive ability would be reduced for the various social insurance benefit categories: "Disease and accidents must be paid for in any case, in lessened power of production and in idleness, if not directly by insurance benefits." (19) "From the standpoint of social security, a health service providing full preventive and curative treatment of every kind to every citizen without an economic barrier at any point to delay recourse to it, is the ideal plan." (20) Beveridge specifically recommended against any charge for use of health services, apart from the general insurance contribution. In the Report, he argued in some detail in favour of comprehensiveness, i.e., the inclusion of all general practitioner, diagnostic, specialist, hospital, rehabilitative and other institutional care, and dental and ophthalmic treatment, with a small charge for appliances only in the latter two cases. Hazardous industries would pay a special levy toward the cost of the rehabilitation service.

The quality and effectiveness of the proposed service was of primary importance to Beveridge, in order that it should fulfill its goals of maintenance of health and productive capacity, and efficient restoration of earning ability after disease or injury. In this way the orientation of Beveridge is significant, and one of the keys to the political popularity of his scheme. For these features of his recommendations for a national health service, Beveridge acknowledged

his accord with aims of the service proposed by the Medical Planning Commission of the British Medical Association. (21) But he differed in recommending coverage for "not ninety per cent of the population (the present insured persons and their dependants), as is assumed in the Draft Interim Report ... but one hundred per cent of the population." (22) This latter point was made in the context of discussing the future of private practice, which he felt should remain as an option for those willing to pay, over and above the public service which would be paid for by and available to all.

Other matters of the structure and organisation of the service were left aside by Beveridge as not relevant to his terms of reference. It was not necessary to express opinions on the issues of "free choice of doctor, group or individual practice, ... the place of voluntary and public hospitals respectively in a national scheme, ... the terms of service and remuneration of doctors of various kinds, of dentists and of nurses, except in so far as these terms may affect the possibility of diminishing and controlling sickness and so [might] affect the finances of the Social Insurance Fund." (23) These, however, from the viewpoint of the medical profession and the voluntary hospitals, were to remain the key issues of debate with the three Health Ministers involved in planning the NHS.

The Medical Profession: The Medical Planning Commission Report

The Socialist Medical Association was in complete agreement with Beveridge's Assumption B and his supporting arguments for a comprehensive and high-quality service, free at time of use. Murray comments that Beveridge had in fact accepted in essence the scheme

earlier developed and publicised by the SMA: "It was the same scheme that was in front of Beveridge and it was that scheme which he accepted. It is clear that Beveridge had read SMA literature on the subject and the Draft Interim Report of the Medical Planning Commission, the thinking of which had been so influenced by its SMA members." (24) Following publication of the Beveridge Report, the SMA used its publicity machinery including its journal, MEDICINE TODAY AND TOMORROW, its BULLETIN, and its occasional pamphlet series, MEDICAL NEWS AND VIEWS, in support of Beveridge's proposal.

The Draft Interim Report of the British Medical Association's Medical Planning Commission, unique among BMA statements in its commitment to the creation of a health service, was less influential with the public, because of its professional orientation, than was the semi-official Beveridge Report. It was, nonetheless, taken very seriously as a planning document in the government, and, as a controversial statement of the goals of only a part of the medical profession, became a focal point for professional debate for several years.

The success of the Emergency Medical Service, and the fervour of reconstruction discussion had prompted the BMA in August 1940 to appoint the Medical Planning Commission, in conjunction with the Royal Colleges. The Commission comprised over seventy members from all of the U.K., with observers from the Ministry of Health. The terms of reference of the Commission were quite general: "'To study war-time developments and their effects on the country's medical services both present and future.'" (25)

The Socialist Medical Association was represented by three members,

Mr Somerville Hastings, Dr D. Stark Murray and Dr H. H. MacWilliam. All three were prominent in both the BMA and the SMA. "Their appointment," Murray notes, "was a measure of the support the SMA had within the profession and a recognition that some changes were inevitable and that the BMA should be aware of what the Labour Party was likely to plan."

(26) Approximately ten of the nearly seventy members of the Commission, some nominated by bodies other than the SMA, were active proponents of a health service.

According to Murray, polarisation developed within the Commission over the issue of a fully socialised, salaried service, which twelve to fifteen influential members would have supported in a minority report had the Commission issued more than its Draft Interim Report. The reason for the early report, which concluded the Commission's work was, Murray suggests, that it became obvious that the Commission "was proceeding very much farther than its terms of reference suggested and would, whatever its conclusions, face the BMA with the alternative of accepting an advanced political view or of repudiating its own Commission." (27)

But the majority sentiment of the Draft Interim Report on most questions of health service policy was relatively conservative. With respect to eligibility, it proposed extending the contributory insurance principle of National Health Insurance to cover dependants, the self-employed, and all others whose incomes were below the existing limit. It is estimated this would have covered ninety per cent of the population, leaving the wealthiest ten per cent to the private medical sector. For the covered population, benefits would be extended to include diagnostic, specialist, dental and ophthalmic services, and

drugs. Hospitals, however, would continue to charge flexible fees based on patients' incomes.

General practice would be given an important place. Both group practices and local authority provided health centres were proposed. The health centres were described in some detail, with attention to their range of co-ordinated services and their close liaison with local specialist and hospital services. While a minority of the Commission favoured a fully salaried service for general practitioners, the Report proposed capitation payments up to a maximum caseload, plus a basic salary reflecting qualifications and experience. Part-time salaries were suggested for specialists. Abolition of sale and purchase of practices was suggested as an eventual possibility, but was not proposed.

The service as a whole would be centralised, under either the Ministry of Health or a semi-independent corporation. The latter idea was later to be pressed resolutely by a section of the medical profession. Payments would be made by contributions from the insured, employers and government to the central agency and paid out to the large regional units responsible for administration and co-ordination.

The Report proposed protection for the voluntary hospitals. They would remain independent, supported by grants-in-aid from the government, and would continue to raise revenue through charity, fees charged to patients, and their own pre-paid contributory insurance schemes. Co-ordination among hospitals would be achieved by grouping both voluntary and public hospitals around a large voluntary or teaching hospital, making a regional unit, directed by a body representative of participating institutions. Regions in turn would be grouped in provincial units. Co-ordination, therefore, was to be achieved

voluntarily among hospitals grouped and represented on two levels, and other medical services, particularly that of general practitioners, would be co-ordinated regionally in a similar representative manner.

Despite its apparent lack of finality, the Draft Interim Report was to achieve the status, through the following several years leading to NHS, of an authoritative statement of progressive thinking within the medical profession. A health service was proposed, but based on the insurance principle and covering only ninety per cent of the population, and excluding hospital benefits. General practice, particularly the private sector of it, was encouraged, as was the financial independence of voluntary hospitals.

The Report was published just in time to be considered by the Beveridge Committee, which took its goals seriously, but disagreed with its proposed limitation of eligibility to ninety per cent of the population. (28)

The British Medical Association took the opportunity of its Annual Representative Meeting in 1942 to pass specific judgement on the 'interim' recommendations of the Medical Planning Commission. It approved all major proposals, particularly those of health centres for general practice and regionalisation of hospitals. However, even the possibility of full-time salaries for general practitioners was overwhelmingly rejected, and a number of matters were left for future decision. The Report itself was discussed both before and after the BMA meeting in discussion groups of doctors throughout the country; many such groups, according to Eckstein, produced their own plans for a health service. He refers to 1942 as a year of "reformist zeal" for the medical profession. (29)

But, Eckstein notes, the profession's zeal for planning at that time may have been aided by the likelihood that no major reforms would be undertaken until after the war. The plan produced by the Medical Planning Commission was, he says:

the most remarkable plan for self-reform in the history of the British profession. The effects of this plan on the profession's attitudes were perhaps as short-lived as they were intense; its effects on government planning, however, were immense. It is certainly a curious fact that the leaders of the profession, during the war, produced precisely the sort of grandiose plan they were so desperately to oppose afterward. (30)

Another report issued from the medical profession in late 1942 was the "Medical Planning Research Interim General Report," published in LANCET (31) by a group of about 400 younger doctors, many in the Armed Forces, and others associated with health services. Like the Medical Planning Commission, it supported substantial reorganisation of general practice into health centres which would provide a wide range of services in conjunction with a co-ordinated regional plan, including hospitals. The authors stressed effective preventive services, including industrial medical services, and a nationally co-ordinated plan to improve the health of children and to restore the productive capacity of the country. The report differed from the Medical Planning Commission in proposing that both health and social security funding be paid through taxes and rates. It did not take positions on many of the matters of administration covered in the former report, but did support payment for practitioners in health centres by basic salary plus capitation, and the maintenance of voluntary hospitals, at least initially, under their existing ownership.

This latter document was perhaps more representative of the

opinions of younger doctors than was that of the Medical Planning Commission. In particular it reflected the greater enthusiasm for publicly organised general practice in multi-functional health centres among younger and Armed Forces doctors. The opinions of this group, as the war and health services discussions proceeded, along with the efforts of the Socialist Medical Association, were to place increasing pressure on the BMA, and ultimately to widen polarisation of opinion in the profession. One issue on which the younger doctors' report did this especially was the abolition of sale and purchase of medical practices, which, from their position either as salaried doctors serving the military, or experiencing great difficulties in establishing a civilian practice, they supported wholeheartedly against much of the rest of the profession which held sale and purchase a nearly sacred part of private practice.

Government Response: The War Cabinet Reconstruction Committee

The recommendations of the Beveridge Report, going so much further than the BMA in proposing compulsory coverage for all of the population, and in inclusion of hospital care as an insured benefit, caused some unease in the profession, and perhaps marked the turn from its "reformist zeal" to a posture of growing defensiveness. Lindsey notes that the cool reaction accorded the Beveridge Report by the BMA was much at variance with the public enthusiasm. (32)

Also at variance with public reaction to Beveridge was that of the government, particularly Prime Minister Churchill. The Beveridge Report was submitted in November 1942. Although various Ministries were studying a variety of reforms in health and social security, no policy

announcement was made until a statement in the House of Commons on 16 February 1943 by Sir John Anderson, Lord President of the Council.

The War Cabinet Committee on Reconstruction Problems (Official Committee on the Beveridge Report) (33) made its recommendations to the War Cabinet in January 1943 on the question of government acceptance of Beveridge's proposal for a comprehensive health service. The Committee's recommendations reflected, in part, the detailed thinking of the Ministry of Health on medical policy questions, and the Committee's thinking on overall strategy. Acknowledging the government's commitment to medical reform and the specific commitment in the House of Commons, 9 October 1941, to postwar provision of a co-ordinated hospital service, the major questions now were seen to be the re-organisation of general practice into grouped health centre practices and the method of payment: full-time salaried service, or an element of competition with capitation fees which would be "unworkable" in a health centre setting. The Committee anticipated that the nearly 6,000 young doctors about to be released from military service would expect some guidance soon about conditions of practice, and would probably be disposed to salaried service. Negotiations with the profession and the other major interests, however, were likely to be long and unpredictable in outcome: "... it is difficult to assign any date for their completion, or to forecast the precise form which the new service will take and in particular how far private practice will persist." (34) The same vagueness of purpose was apparent in the final recommendation of the Committee, that the government should make a single general announcement of its intentions with respect to the Beveridge Report.

A more detailed presentation on the question of the government's

commitment to a health service was made to the War Cabinet in early February 1943 by the Minister of Health, Mr Ernest Brown, and the Secretary of State for Scotland, Mr Tom Johnston. While similar in general principles to the report of the Committee on Reconstruction Problems, it presented certain new emphases in the organisation of the scheme.

It stressed that local authorities must be the administrative base of the service, grouped into uniformly large, workable regional units to co-ordinate the hospitals and the general practitioner service, for which health centres were favoured: "The comprehensive health service must be one and indivisible in each area of the country." Voluntary hospitals would remain under present management, but would have to conform to regional standards of facilities and services, staffing and salaries, and admission policy in order to receive subsidies. The question of direct payment by patients for hospital care was termed "difficult" and left for later consideration.

Private practice was seen as an important issue for doctors already in practice -- they should have the option of part-time public service; but for younger doctors not yet established, the Ministers expressed "no doubt that they should be under an obligation to give full-time service," with perhaps a later option of part-time service depending on public demand. The Ministers noted the strong demand by younger specialists for a full-time salaried service but felt a flexible arrangement of optional part-private practice was desirable.

Freedom of choice of doctor was seen as relative to the availability of doctors, but important to preserve in principle. Exclusion of ten per cent of the population, as the BMA had proposed

would be "unworkable"; there was "no ground on which exclusion could be justified," especially if the plan were financed from taxes and rates. The inclusion of the whole population, on the other hand, need not rule out the option for both doctors and patients of private practice. The profession's fear of lay control should be allayed by adequate medical representation on local, regional and national committees. The question of salaries was left unsettled, although the Ministers expressed disagreement with the BMA's contention that free choice of doctor could be preserved only by payment of doctors on a competitive, for example capitation, basis. They felt a salary option for younger doctors only, at a reasonable rate and with superannuation, would go some way to remove the fears of older doctors of salaried service. The Ministers finally and decisively recommended against the gradual extension, in stages, of National Health Insurance. Rather they suggested early legislation for uniform application of a comprehensive tax-based service, as in the best interests of practising doctors and those about to leave military service, the local authorities and the public. (35)

Two subsequent memoranda to the War Cabinet on health service policy aspects of the Beveridge report indicate some indecision resulting from a division of opinion on the matter of universality of coverage (the vexed 'ninety-per cent' question raised by the BMA), but agreement on the urgency of a policy statement and commencement of negotiations which were in any case likely to be long and difficult. The first of these summary memoranda from the Committee on Reconstruction Priorities proposed announcing the government's commitment to a comprehensive health service, but its reservation of the issue of universal coverage versus restriction to only part of the population.

(36) The second memorandum, only days later, recommended both acceptance of the principle of universal coverage and reassurances that private practice and voluntary hospitals would continue. It cautioned, as did the preceding memoranda, that it would be many years before there would be sufficient manpower to provide full dental and ophthalmic services, and that the ultimate shape of the service could be determined only through detailed negotiations with all concerned organisations. But, there was urgency to proceed -- the medical profession had indicated both readiness and enthusiasm in the Medical Planning Commission Report, and a large number of demobilised doctors would be looking for secure places in a new postwar health service -- therefore discussions and negotiations should be opened at once. (37)

Earlier interdepartmental correspondence between the Ministry of Health and the Treasury concerning health service proposals indicated much less caution on the issues of freedom of choice of doctors, salaries and health centre practice than did War Cabinet Committee papers. It was the opinion, for example, of Permanent Secretary Sir John Maude at the Ministry of Health, that existing freedom of choice of doctor was almost absent in rural areas, and little exercised in the large towns; this was demonstrated in the success of the sale of 'good will' of medical practices (i.e., the sale of a list of the doctor's clientele) to which most patients submitted readily. He commented that the right of free choice must, however, be preserved, and significantly, that it could most realistically be exercised in a health centre context, where the patient would have free access to any of several doctors. This practical form of free choice would not be affected by a salaried method of payment of the doctors. He felt that postwar health

centre building should be undertaken energetically, even if it meant adapting old properties and making use of surplus Emergency Medical Service Equipment. As for private practice, his feeling was that it could not be eliminated, but that it would not likely be popular with the younger generation of doctors. Special emphasis would be needed to integrate general and specialist practice, and public health and preventive work; both research and medical recruitment would be enhanced by the establishment of a health service. (38) These opinions expressed to a Treasury official are perhaps indicative of thinking among senior Ministry of Health officials in the opening months of the several difficult years of preparation for the NHS. They are notably oriented toward the proposals of the BMA Medical Planning Commission, but express a significant independence of view on the especially emotive questions of free choice of doctor and its relation (or non-relation) to method of payment, and health centre practice. A sense of urgency in getting on with preparations is evident in the correspondence.

That same sense of urgency pervaded the War Cabinet Reconstruction Priorities Committee documents, and the joint Ministers' proposal to the War Cabinet referred to above. The reaction of the Prime Minister, however, to the entire issue of implementation of the Beveridge proposals was cool. He was personally on record as opposing any government encouragement of optimism ("false hopes," as he put it) about postwar social change. In a much publicised incident, a summary of the Beveridge proposals intended for distribution to the armed forces was withdrawn on War Office orders, which began a process of erosion of public confidence in the Churchill government's social policy intentions, and of confidence in Churchill himself.

Churchill was responsible for the statement made in the House of Commons in February 1943, three months after publication of the Beveridge Report, merely welcoming it and giving no indication of Government action. (39) This clear lack of commitment to legislation prompted nearly one hundred Labour Members of Parliament led by Arthur Greenwood, who had appointed Beveridge, to support an amendment in favour of implementing the proposals. Lloyd George with several Liberals and a number of Conservative backbenchers also supported it. The amendment was defeated, but the backbench revolt, together with the wide publicity given to the Conservatives' equivocation over Beveridge's plan, did, according to Calder, ". . . as much as anything to bring about the Labour Party's electoral victory in 1945," (40) and, contrary to Churchill's wish, heightened public pressure for implementation.

The government, following Churchill's embarrassment at the publication and the publicity and massive popularity surrounding the Beveridge Report, did not consult Beveridge further during the ongoing departmental discussions about his plan, and he was not involved in preparation of any of the White Papers of 1944 which summarised official thinking to that point. The Conservatives had been put in a dilemma by Beveridge: "Churchill was interested only in the prosecution of the war, and the government was enabled to hold together [the Coalition] by pursuing that aim and avoiding controversial issues of domestic policy. Under these circumstances the Labour Ministers were chagrined to have Beveridge steal their thunder, and were cool in their response, greatly to the concern of the Labour rank and file, while Churchill may well have been aiming to have the Plan up his sleeve for post-war reconstruction in which Labour, he hoped, would have no part." (41)

The February 1943 House of Commons announcement accepted in principle Beveridge's three assumptions, including a national health service. While the long delay in making any policy statement and the generality of the commitment made in February gave the impression to the public that the government had been delaying (as indeed Churchill had), much detailed preparatory work had by then been undertaken by the Ministries concerned. The commitment within the Ministry of Health for a national health service had taken it much further in its internal discussions than the government was prepared to support in public by the spring of 1943.

Progress to Early 1943: Health Service Models and Interests

By now it was clear that the Ministry had recognised the fundamentally different and opposing approaches to, or models of, reorganisation of the nation's health services. The debate over these approaches, which had been developing among the medical profession, and the health service advocates, was now being internalised within the planning agencies of the state, especially with the experience of the Emergency Medical Service. A twofold process was beginning, a reappraisal by the state of the social definition and organisation of health, and an assessment of the viewpoints and interests to be consulted or represented in designing the new health services.

The Ministry of Health -- both the permanent officials and the Minister -- had reached the determination that the nation's health, a critical factor in national industrial and military efficiency and postwar recovery, was very much dependent upon socially related risk factors, and upon the limited effectiveness of existing insurance and

medical arrangements. The popular political expectation of universal, non-discriminatory health and social services was becoming undeniable. But for the restrictions on political competition imposed by the Coalition, there would probably have been open political rivalry on this issue, with Labour and Conservatives anxious to claim credit for the new social service. The Parliamentary dispute over action on the Beveridge Report was ample evidence of the political importance of the burgeoning welfare state.

Beveridge himself had redefined health in the context of economic security and productivity, and had pointed out the dysfunctionality of National Health Insurance and the Approved Society system to the maintenance of health. PEP had developed a similar critique of the ineffectiveness of medical and insurance services. Both had redefined the organisation of health services not as an end in itself but as a means to the end of health and productivity for the nation. In the face of these reports, and the others of the 1920s and 1930s, to which reference has been made, and the political pressures generated especially by Beveridge, the Coalition determined in early 1943 to include a comprehensive, regionalised health service in its reconstruction plans.

By this time, a good deal of thinking about the general principles of the scheme had gone on within the Ministry. Beveridge's opinion that it should apply to all persons had been accepted against the view of the BMA that the wealthiest ten percent should be excluded. Beveridge's view that the scheme should be financed through a single contributory insurance scheme had been rejected in favour of a tax-based service, with eligibility as of right rather than through contribution. The

scheme was to be comprehensive, that is, including in addition to general practitioner services, hospital and specialist services, a view opposed by the BMA and BHA which wished to retain independent hospital fees and insurance.

In arriving initially at these general, overarching principles for the reorganisation of health services, the Ministry, and the Cabinet in so far as it occasionally debated and ratified the Health Minister's proposals, were beginning to establish the bases for the representation of interests which was to take place later in the stages of detailed policy formulation. The views were now known of most of the major interests, especially of the BMA through its Draft Interim Report. The Labour Party with the Socialist Medical Association was formulating plans for a state-operated scheme based upon the principles of prevention and equality of access to first class services. And other interests were preparing for their defence in the conflict anticipated over the arrangements for the service. The planning process of the state for the NHS was underway, and certain aspects of a representation of interests were taking shape following the decisions of the War Cabinet in favour of a universal, comprehensive, tax-based service.

Even though the medical profession was to be denied its 'ninety percent', insurance-based, non-comprehensive scheme, it was to be well represented in further detailed planning, according to the memoranda to Cabinet of the Minister of Health. It was also clear that even though private practice was under severe criticism, and some consideration was being given to a salary option for young doctors (in lieu of purchasing a private practice), it was not at all fundamentally in jeopardy. Despite the much publicised fears of the BMA in 1943, Ernest Brown's

memoranda to the War Cabinet indicate as conclusively as can be determined that he was not considering a fully salaried service. On the contrary, it was apparent that he wished to retain the confidence of the medical profession, and wished to begin negotiations with them as soon as Cabinet approval was obtained. A firm commitment was also apparent at this stage to the local authorities as the basis for regional unification and integration of all branches of the service. The functions of the local authorities would be further aggrandised through maintaining the network of health centres, then in an early stage of consideration.

With respect to their prior commitment to a universal and comprehensive service, Ministry officials and the Minister were evidently dedicated to the rational critique and perspectives of Beveridge and PEP, much of which coincided with the position of the SMA in favour of a state service. This view was based on the belief that only a service covering all persons and all risks would serve, and be seen to be serving, the national interest. In later campaigning, the SMA, Labour Party and TUC were to elaborate a model based more clearly on the interests of the working class. At this early stage of planning, however, the chief concerns of the state were with the broadest principles of the scheme, and with the role and representation of the traditional interests in the health services.

CHAPTER 3 — FOOTNOTES

1. Angus Calder, *THE PEOPLE'S WAR - BRITAIN 1939-1945* (London: Panther Books, 1971), p. 622.
2. Eckstein, *THE ENGLISH HEALTH SERVICE*, p. 34, n. 31, lists and discusses the ten surveys.
3. R. M. Titmuss, *HISTORY OF THE SECOND WORLD WAR: PROBLEMS OF SOCIAL POLICY* (London: HMSO, 1950); Eckstein, Chapter 4.
4. Eckstein, *THE ENGLISH HEALTH SERVICE*, pp. 57-62.
5. *Ibid.*, p. 74.
6. Titmuss, *PROBLEMS OF SOCIAL POLICY*, Chapter V.
7. Eckstein, *THE ENGLISH HEALTH SERVICE*, p. 88.
8. Titmuss, *PROBLEMS OF SOCIAL POLICY*, p. 74.
9. Eckstein, *THE ENGLISH HEALTH SERVICE*, pp. 94-95; Titmuss, *PROBLEMS OF SOCIAL POLICY*, pp. 447-449; Calder, p. 622.
10. 374 House of Commons Debates (HC Deb), 9 October 1941, col. 1116.
11. Eckstein, *THE ENGLISH HEALTH SERVICE*, p. 89. See also *ibid.*, p. 97, and Titmuss, *PROBLEMS OF SOCIAL POLICY*, p. 467.
12. *BRITISH MEDICAL JOURNAL*, ii: Suppl. 231, 1939. (Correspondence), quoted in Matthew J. Lynch and Stanley S. Raphael, *MEDICINE AND THE STATE* (Springfield, Illinois: Charles C. Thomas, 1963), p. 130.
13. Titmuss, *PROBLEMS OF SOCIAL POLICY*, pp. 472 ff., describes the "Clyde Basin Experiment", a regional, co-ordinated, preventive service involving general practitioners and hospitals, for war workers in the Scottish industrial belt. He notes also lessons learned from other regional hospital arrangements.
14. *Ibid.*, pp. 487 ff.
15. *Ibid.*, p. 517.
16. Sir William Beveridge, *SOCIAL INSURANCE AND ALLIED SERVICES*, Cmd. 6404 (Beveridge Report) (London: HMSO, 1942). The Beveridge Report is discussed in some detail in: Calder, pp. 607-619; Ross, pp. 80-84; Bruce, Chapter 7; Eckstein, *THE ENGLISH HEALTH SERVICE*, pp. 133-136; Fraser, pp. 198-204.
17. Calder, p. 608.

18. Fraser, p. 201.
19. Beveridge Report, p. 158.
20. Ibid., p. 162. See also T.H. Marshall, SOCIAL POLICY (London: Hutchinson, 1965), pp. 76-83, regarding the extent to which Beveridge's principles and recommendations were implemented.
21. Beveridge Report, p. 159. The BMA Report was published in the BRITISH MEDICAL JOURNAL, 20 June 1942.
22. Beveridge Report, p. 160.
23. Ibid., p. 159.
24. Murray, p. 57.
25. Ross, p. 78.
26. Murray, p. 46.
27. Ibid., p. 48.
28. Beveridge Report, pp. 159-160. The British Medical Association is not listed among organisations submitting evidence to the Beveridge Committee. Beveridge, Appendix C, p. 247.
29. Eckstein, THE ENGLISH HEALTH SERVICE, p. 122.
30. Ibid., p. 118.
31. "Medical Planning Research - Interim General Report," Supplement to THE LANCET, 21 November 1942, pp. 614-617.
32. Lindsey, p. 32.
33. Public Record Office (PRO), Cabinet Papers (CAB) 87/3, R.P. (43)6, War Cabinet Committee on Reconstruction Problems, 14 January 1943.
34. Ibid., para. 64.
35. PRO, CAB 87/13, P.R. (43)3, "A Comprehensive Medical Service: Memorandum by the Minister of Health and the Secretary of State for Scotland," 2 February 1943.
36. PRO, CAB 87/13, P.R. (43)9, "Draft Interim Report on the Beveridge Plan," 7 February 1943.
37. PRO, CAB 87/13, P.R. (43)13, "Interim Report on the Beveridge Plan," 11 February 1943.
38. PRO, Treasury, T161, Box 1166, letter from E. J. Maude, Ministry of Health, to Sir Alan Barlow, Treasury, 18 November 1942.

39. Fraser, pp. 202-203; Calder, pp. 612-614.
40. Calder, p. 614. See also Alan Bullock, THE LIFE AND TIMES OF ERNEST BEVIN, Vol. II (London: Heinemann, 1967), pp. 224-233, for a discussion of the role of the Labour Ministers and the Parliamentary Labour Party in attempting to strengthen the government's commitment to Beveridge, and the aftermath of the backbench revolt in February 1943.
41. Bruce, p. 310.

CHAPTER 4

THE ADVOCATES OF A NATIONAL HEALTH SERVICE:

GROUPS AND ISSUES IN THE EARLY PLANNING PERIOD

Once it was clear that political pressures and the force of economic circumstances were great enough to move the state to a major reorganisation of health and social services, as part of its more general intervention in the restructuring of economic relationships, the time had clearly arrived for the second stage of planning, that of detailed policy making by the state, which the various interests now worked to address.

The organisations discussed in the following sections, the Labour Party, the Socialist Medical Association, the Trades Union Congress and the Medical Practitioners' Union, represent the major sources of planning, organising, and publicising in the early part of the campaign for a comprehensive health service. Other organisations were also active; these we shall encounter in due course, their activities generally feeding into those of the main proponent groups.

The Labour Party and the TUC had perhaps the greatest claim to be taken seriously in government policy planning -- the Labour Party being a partner in the Coalition, and the TUC as part of the tripartite structure of wartime economic decisionmaking. The Labour Party could also assume that it would have the power to make policy directly, provided it won the next election. Thus it was of critical importance that both organisations prepare relatively detailed policies as the

basis for rallying opinion and ultimately for legislation.

The SMA and the MPU were, in effect, the 'brains trusts', or repositories of expertise, respectively for the Labour Party and the TUC in their policy planning endeavours. The SMA was primarily a political organisation, dedicated to the advocacy of a state health service according to socialist principles (which, in its literature, were more assumed than elaborated). The MPU advocated an essentially similar type of service, from its perspective as a small trade union concerned with conditions of work for medical professionals. The SMA was (and remains) affiliated to the Labour Party, the MPU to the TUC.

There were, of course, considerable overlaps of interest and membership among these organisations. Indeed they were all represented together in the National Council of Labour, a co-ordinating body representing the Labour Party, the TUC, and the Co-operative Union; the SMA and the MPU were represented with respect to health service policy, on the delegations of their senior organisations.

In the following sections, we examine the internal health policy-making processes of these four bodies, their progress and difficulties in formulating a common policy (noting some early differences of opinion, particularly over industrial health strategy and local medical representation), their public advocacy activities, and their initial attempts to press their case for a state health service with the Ministry of Health.

Labour Party Health Policy Planning, 1941-1943

In March 1941 the Labour Party's reconstruction planning machinery, through a series of partly overlapping committees set up under the

National Executive Committee (NEC) of the Party, began to grapple with questions of postwar Labour policy. The several committees, dealing with education, health, social insurance and services, industry and finance were later rationalised as sub-committees of the party's Central Committee on Reconstruction, closely paralleling those Ministerial and interdepartmental committees charged with considering in detail the implementation of the Beveridge recommendations.

The Labour Party began its reconstruction planning in 1941. The Public Health Advisory Committee of seven members met in March at the House of Commons. (The announcement noted that respirators were required for those attending.) The meeting was chaired by Mr Somerville Hastings MP, long prominent in the Socialist Medical Association, the Labour Party, and the London County Council. The task at hand was to dust off and examine the party's 1934 conference policy, "A State Health Service," itself a product of earlier work by the Socialist Medical Association, and to look at Somerville Hastings' 1941 paper, "A Scheme for a Wartime National Medical Service."

By the group's second meeting in May 1941, several medical and other expert members had been co-opted, making the full complement of fifteen, including Dr David Stark Murray, also a well-known member of the SMA. The government's Emergency Medical Service, along with other circumstances, brought into sharp relief the task of the Committee. There was a good deal of urgency to produce a detailed party policy aimed at developing a complete civilian service from these wartime beginnings. The Labour Party would have to update its own and SMA proposals, reflecting its pre-war social priorities and wartime experience, into a policy tailored for implementation in the latter

stages of the war or immediately after the peace.

The Public Health Advisory Committee met five times between March and October 1941 to consider memoranda on two aspects of health services long given top priority by the SMA: health centres and an industrial health service. While these programmes were not the exclusive proposals of socialists, they were considered intrinsic to a socialist health plan; both would bring the preventive and curative services of medicine much closer to ordinary people.

In a memorandum to the Committee in October 1941, recapitulating both Labour's 1934 conference proposals for health centres and the Committee's discussions of the preceding months, Dr David Stark Murray set out in detail the characteristics of the health centre service agreed upon. It would be a service presupposing and parallel to a unified hospital service (as opposed to dual municipal and voluntary systems); it would be nationally organised, but with both health centre and hospital services planned locally for population units of about 100,000. The work of health centres was summarised in some dozen points:

1. Periodic general medical examination of all patients registered
2. Surgery work of general practitioners to be located in the centre
3. To be the base for domiciliary services of general practitioners
4. To take over some of the work of hospital casualty departments
5. To make use of the services of consultants both in the centre and in patients' homes
6. Specialised local authority health services to be included and co-ordinated

7. Full dental services to be located in the health centre
8. Foot care to be provided
9. Accident and factory medical services to be included at the centre, and co-ordinated with existing services in factories
10. Rehabilitation and occupational therapy; laboratory and X-ray facilities to be included
11. Pharmaceutical departments would dispense drugs and supplies
12. Health education and propaganda to be organised for the centre's catchment area

The idea was not to alter the basic pattern of medical work of the general practitioner, rather to locate the practitioner with co-workers in premises where ancillary services would be available. The centre would be closely linked with the hospitals covering the same catchment area, in such a way that the specialists would be available for consultation even in the home, as arranged by practitioners at the centre. Local authority services in the same building would comprise midwifery, health visitors, social welfare workers, home nursing services and home helps. Nurses, to broaden their experience, would work alternately in hospitals and health centres in the area. Social workers, home nurses and others would be concerned with the same cases as practitioners, when necessary. Teamwork would be the new emphasis in the health centre form of general practice. Comprehensive medical records, comparable in form with those in other health centres, would be kept, and could be transferred as necessary. (1)

The Committee had agreed by this time that a health service should be the full responsibility of the Ministry of Health, with the Minister answerable for it to Parliament, that only publicly elected authorities should be in charge of the service, and that the unit of administration

should be as large as possible, if necessary involving co-operation between adjacent local authorities.

In the autumn of 1941 the Committee considered several papers advocating plans of gradual transition to a full state service. One such paper, for example, proposed first the transfer of Emergency Medical Service hospitals to a fully public function, and contractual arrangements with voluntary hospitals for public service. It was proposed that after the war, Labour-controlled local authorities should by agreement take over voluntary hospitals, uniting them in a single superior system with municipal hospitals. On October 9, 1941, Health Minister Ernest Brown announced in the House of Commons the government's intention to establish a local authority-based system, essentially similar to the Committee's proposals. The apparent disadvantage of such a scheme of voluntary co-operation by the voluntary hospitals was that the managerial structure of the Emergency Medical Service hospitals on which the scheme would be based was so dominated by voluntary hospital interests that they would stand to inherit general control after the war.

A policy paper by Somerville Hastings, taking something of a 'gradualist' position, noted: "The conditions for the development of a municipal hospital system will, therefore, probably become much more favourable soon after the war, and will be best achieved by 'Fabian' methods." (2) He recommended against government takeover of voluntary hospitals, a move which would be attacked as "confiscation," and in favour of charging local authorities with the duty of providing hospital services for all willing to use it, while providing contractual payments for voluntary hospitals conforming with a regional plan. The plan would

cover standards of service, admission of patients solely on the basis of medical need, (3) staff hiring policy, pay, and working conditions, which would be uniform with those of the local authority hospitals. These would be the requirements for shared funding. Hospital treatment would be made free only when postwar financial stringency eased, thus promoting the later assimilation of non-contracting voluntary hospitals. A natural development would be the combining of local authorities to form hospital regions. The Committee decided to solicit the opinions of certain provincial Labour Party members and officials on these proposals.

In the Committee's papers, the structure of a health service as a whole continued to be developed in increasing detail. In particular there were proposals for a national maternity service, and for determining optimum population groups to be served by planned and decentralised health facilities. One paper envisaged an operational unit consisting of one general hospital of up to 1200 beds for a population area of 100,000. Around this would be grouped a few Divisional Health Centres for specialist and consultant services in close association with the hospital, and Local Health Centres comprising about 50 general practitioners in all, scattered in teams of 3 to 12. Health centre features agreed upon earlier were reiterated, and certain additional ideas proposed. "Industrial hygiene," for example, would be part of the work of all doctors, who would have authority to require changes in conditions of work in factories, shops and offices. Administration of the service as a whole would be based on large regions centred on a university medical school, and would be representative and responsible through election. This same paper proposed as a first step,

the compulsory establishment by local authorities, with central funding, of a variety of specialist clinics, including industrial health, to be available both to those insured under National Health Insurance and those not insured. (4)

Further elaboration of the national maternity service was provided in a paper submitted by the Women Public Health Officers' Association, a trade union affiliated to the Trades Union Congress and comprising mainly health visitors. Their proposals included, among other items, ante- and post-natal care organised at health centres, midwifery and supervision of home confinement.

Between February and April 1942, the Committee dealt with detailed proposals for the health of children including a school medical service, and a tuberculosis policy. Lady Simon, author of the school medical proposals, stressed co-ordination and regular contact between school and health centre medical services.

By May 1942, the Public Health Sub-Committee was able to issue its interim report, "A Scheme for a State Medical Service." (5) As in the earlier draft proposals, a consistent point of emphasis was co-ordination of all branches of the service, particularly the linking of the general practitioner health centres with domiciliary and hospital consultant services. Other points agreed upon earlier were restated in the interim report with special stress on easy accessibility for people in their own area to comprehensive and co-ordinated health and welfare services.

Some time appears to have been lost during the summer of 1942 by the Labour Party's Central Committee on Reconstruction, in approving the proposals of the Public Health Sub-Committee. When the Sub-Committee next

met in November 1942, it complained to the senior committee that other bodies were already publishing health service proposals -- indeed the Beveridge Report was released the same month -- while the Labour Party had so far failed to do so despite the basic documents having been ready in October 1941.

In December 1942 the Sub-Committee turned its attention to the urgent matter of tuberculosis. It arranged to send a deputation to the Parliamentary Labour Party to discuss immediate programmes of mass radiography, nursing, and rehabilitation, and industrial conditions as they related to tuberculosis control and prevention.

A document intended for public distribution, entitled "Labour's Plan for Health" (6) was approved in December. It summarised decisions of the group to date, stressing comprehensive regionalised services maintained by single and joint local authorities, and salaries and improved and regulated conditions of work for doctors. It noted also the urgency of beginning a service before the end of the war.

By January 1943, the Reconstruction Committee's policy congestion had given way to the pressure to produce final policy documents for the Annual Conference of the party. A draft resolution on health was prepared for sponsorship by the National Executive Committee (NEC); it was further approved by a joint medical committee of the Trades Union Congress, the Co-operative Congress and the Labour Party. The only point of contention to be raised at this stage was the recommended local administrative structure. While the Labour Party committee envisioned a large part of the service under the administrative control of local authorities, the Medical Practitioners' Union (MPU) sided with the historic objection of the medical profession to local authority control,

and demanded instead a regional planning and administrative structure with strong medical representation.

In the Social Insurance Sub-Committee, meanwhile, a summary statement had been issued following the release of the Beveridge Report. It welcomed the Report as conforming to Labour's 1942 Conference policy, called upon the government to implement the proposals, and suggested the Parliamentary Labour Party should have the power, in the Coalition, to make amendments. (7) Early in 1943 detailed comparisons were made of Beveridge's recommendations, party policy, and announced government policy, (8) as part of preparations for the 1943 Annual Conference, at which an item of major importance would be the party's reconstruction policy. (The Conference was to be held in mid-June 1943 at Central Hall, Westminster.)

The March meeting of the Public Health Sub-Committee was the last before the Conference. In addition to final drafting of the NEC resolution on health policy, a draft was also completed of a pamphlet, "A National Service for Health," which would be launched in a national Labour Party campaign following the Conference. In April these drafts were approved by the senior Central Committee on Reconstruction Problems, along with statements on the Beveridge Report and on social services in general. This was the final stage of policy formulation before submission to the Conference.

At the Annual Conference, debate on what was now the National Executive Committee's resolution on health policy took place in the shadow of the considerable split in the Parliamentary Labour Party as a result of the Commons debate in February on the Beveridge Report. In the Commons, the Coalition Cabinet, including the Labour Ministers, had

committed the government merely "in principle" to sixteen of Beveridge's twenty-three recommendations and only to the preparation of legislation, any decision on implementation to rest with the first postwar government. (9) This proposal, combined with the Conservatives' apparently half-hearted attitude in debate toward the entire scheme provoked nearly all members of the Parliamentary Labour Party, led by Arthur Greenwood, who had appointed Beveridge, to break ranks with the Labour Ministers and vote against the Government.

At the Conference, the National Executive Committee's resolution on the Beveridge Report welcomed it "as a valuable contribution to the well-being of those suffering want through adversity and an important advance toward democratic social policy such as the Labour Party envisages as an essential part of its postwar plans." While admitting need for interim improvements, it called for preparation of major items of legislation for a National Medical Service, for Children's Allowances, and for measures to promote full employment, to be implemented at the end of hostilities. Mr Clement Attlee, a Minister of the Coalition government who had remained loyal to it in the Commons debate, said the government had accepted the Beveridge Report's principles: "... every phase of it, every aspect of its assumptions is being pursued day by day with utmost vigour." (10)

Opposition to the NEC position came in the form of an amendment proposed by Mr S. Silverman MP congratulating the Parliamentary Labour Party for recording its distrust of the government's intentions with respect to Beveridge and calling for immediate legislation to secure the implementation of the Report's recommendations. He noted this was the first time since entering the Coalition in 1940 that a majority of the

Parliamentary Labour Party had opposed the government in a division in the Commons. It was essential, he said, that the party affirm its socialist principles, and asked the conference to vote for an amendment indicating support for the Parliamentary group, against the position of the National Executive Committee which maintained support for the Coalition government. The Executive was supported, among others, by the Transport and General Workers, and by Arthur Greenwood, who cautioned that withdrawal from the Coalition Cabinet would be suicidal for Labour. The Executive and the Labour Ministers were upheld in a vote on Mr Silverman's motion by a margin of two to one, and the Conference turned from the general issues of action on the Beveridge Report to its own policy for health. (11)

TRIBUNE, journal of the Labour left, had during 1943 taken a position highly distrustful of the government's intentions with respect to Beveridge's health and social security proposals, and had supported Labour backbenchers in voting against their Ministers in the Commons in February. TRIBUNE did not, however, go so far as to suggest that Labour withdraw from the Coalition. Aneurin Bevan, future Minister of Health in the 1945 government, writing just after the Commons debate, had harsh words for Labour's Parliamentary leaders. Backbenchers well knew the popularity of the Beveridge Report in the constituencies. But, he remarked, the implicit condition of participation in the National Government was that Labour "drop its programme of social regeneration and help to put across the plans of vested interests. ... Only a leadership determined to lose the political initiative could have thrown away the possibilities presented by its relationship with the Beveridge Report." While the Parliamentary Labour Party supported Beveridge, "the

General Council of the TUC were on record supporting Clement Attlee, Ernest Bevin and Herbert Morrison in their wrecking of the Beveridge Plan." (12) He noted the division in the TUC over this position; the leadership would defy the pro-Beveridge opinion of the members at their peril -- a split existed between political and industrial labour. Bevan urged the rank and file to make clear to TUC and Labour Party leadership their support of Beveridge. Bevan's only other comment in TRIBUNE before the party conference, however, was a plea for more freedom for Labour within the Electoral Truce, to fight byelections, and to set the political terms of its participation in the Coalition. (13)

At the Conference, Bevan made his only major contribution in the debate on strategy for the Beveridge plan, following the spirit of his earlier statements. While not advocating withdrawal from the Coalition, as some in the Labour left wished, he noted that the national unity of which Labour had been the author in 1940 had become "... an instrument of blackmail in the hands of the Tories The Executive's Report was not leadership, it was bankruptcy." (14) Bevan's concern at this point was with Labour's overall political initiative, of which commitment to thoroughgoing action on the Beveridge proposals was only a part. His comment in TRIBUNE after the Conference was typically terse: ". . . the attitude of the Party toward the Beveridge Report has been proclaimed with quite bewildering ambiguity." (15)

Health service proposals were debated at the 1943 Conference after the "ambiguous" debate on Beveridge. The National Executive Committee's special resolution, "A National Medical Service" was moved by Mrs Barbara Ayrton Gould. The resolution, since it is the major reference point for the future Labour Party health policy is here quoted in full:

This Conference,

Believing that the nation needs a Medical Service which is planned as a whole; fitted to prevent, as well as cure, ill health; complete, including all kinds of treatment and advice required; and open to all irrespective of means or social position; and

Believing that these needs are not adequately met by the existing service, and can only be met by a State Medical Service, nationally planned, regionally administered and paid for out of public funds,

Calls for the organisation of a State Medical Service as soon as conditions permit.

To this end the Conference recommends that

(a) The Ministry of Health, responsible to Parliament, should be empowered to plan the Health and Medical Service broadly for the whole nation, and to exercise supervision and general control to ensure the carrying out of the plan

(b) The Medical Service should be financed through taxes and rates, the bulk of the cost being defrayed through percentage grants from the State to Regional Authorities for approved health expenditures

(c) Regional Authorities should organise the hospital accommodation in their area, the voluntary hospitals being brought into the scheme

(d) Regional Authorities should be required to establish Divisional and Local Health Centres

(e) Doctors for the Service should be enlisted for whole-time, salaried, pensionable service, and should be paid out of public funds

(f) The whole Service should be made available to all, irrespective of means. (16)

A supplementary resolution submitted by the Socialist Medical Association called on the government "to provide forthwith a complete Industrial Medical Service," its medical officers to be appointed by the government (not by employers as company doctors). It urged the labour movement to consider health a direct concern at the workplace and to appoint workers' Health Committees in factories, to supervise conditions

of health and safety in the place of employment. The SMA also introduced a resolution urging full implementation of Beveridge's Assumption B, with a "free, comprehensive, co-ordinated, salaried Health Service" (17)

It would appear from the fact that the SMA introduced these resolutions separately that it, too, felt the Executive's resolutions on Beveridge and on the health service issue to be lacking -- both in urgency of commitment, and in commitment to an industrial health scheme. The latter had come to be a very important plank in the SMA platform by 1943, after its studies of poor health conditions and facilities in war industries and subsequent policy discussions.

In its Annual Report to the Conference, the National Executive Committee announced in particular its acceptance of Beveridge's recommendation for a comprehensive health service of the best standard for all citizens. The statement recalled the 1941 proposals of Health Minister Ernest Brown (which anticipated some features of the Coalition Government's 1944 White Paper) to which Labour's left wing and the Socialist Medical Association were opposed. "While it is likely," the Executive said, "that elements of private practice and voluntarism may play their part in a comprehensive scheme, these must not be allowed to conflict in any way with the maintenance of adequate standards of health services for every citizen." (18)

Now, introducing and elaborating upon the special resolution for the Executive, Mrs Ayrton Gould could outline the two notable omissions in the Executive's report on Beveridge. Two major areas, mental health and industrial health, were left out. The latter, the Conference was reassured, was to be discussed with the National Health Committee of the

TUC and a joint statement to be incorporated in the National Executive Committee's next report.

The foundation of the NEC's proposal was co-ordination of the new Medical Service by the Ministry of Health, assuring responsibility for it to parliament, and the responsibility of regional authorities to implement the scheme in conformity with various local authority structures, which would also "incorporate" voluntary hospitals. The precise status of ownership of the hospitals was not indicated. Health centres were to be "the crux of the whole scheme," as centres for their surrounding neighbourhoods of preventive and curative health services. Again, the two-tier system of divisional and local health centres was stressed as the ideal structure to integrate general practitioner and consultant services. The local centres would be easily accessible, and would be staffed by "salaried, pensionable doctors." There would, as far as possible, be free choice of family doctor. Such a service would have significance beyond individual treatment: a healthy nation was essential to postwar production and reconstruction, happiness and vigour, Mrs Ayrton Gould concluded.

Next to speak in debate on the Executive's resolution was Mr Somerville Hastings MP. He noted that ten years had elapsed since he first moved a resolution for a State Medical Service at a Labour Conference. The task now was to organise as much pressure as possible from the Conference, and from "all the working class movement" for a health scheme, and against "reactionary forces" likely to hinder its achievement. Mr Hastings had clearly by now consolidated his opinion in favour of an all-public service, and had moved some distance from the compromise with private institutions, notably the retention of the

voluntary hospital system, contemplated in the Sub-Committee discussions of 1941. A key principle of the scheme, he now said, was that doctors and staff should give their undivided attention to public service: "Therefore, I think it follows that there can be no place in such a service for the panel and for the voluntary hospital scheme, by which doctors give part of their time to their public duties and part to their private practice." (19)

This was perhaps the most unequivocal expression of support for a wholly public hospital service to be made in Labour Party debate, and stands in notable contrast to the Party's acquiescence to the Coalition White Paper the following year, especially with respect to the status of voluntary hospitals.

Dr Edith Summerskill MP supported Mr Hastings' position. The Conservative interpretation of Assumption B would mean only an extension of the system of charitable voluntary hospitals, extended National Health Insurance and competitive private practice. Within such a basic structure the potential of health centres to revolutionise general practice could certainly not be attained. The alternative, she said, was the socialist method: co-ordinated health services, abolition of voluntary hospitals as well as the profit motive in medicine and a salaried medical service. Doctors in private practice should also be included in a salaried medical service. Conference, she said, must make it clear to Labour members of the government that they reject the Conservative interpretation of Assumption B: health services would be the first indication of the government's intentions. Labour members would be able to test the influence of their Ministers; there would be a split in the Labour Party if there were any compromise. With these stern

words, the resolution was carried. (20)

Unity was preserved in support of the Executive's resolution, but the division in the Parliamentary Party could not entirely be hidden at the Conference. The Socialist Medical Association and the Amalgamated Engineering Union supported stronger commitment to implementation of Beveridge's health service proposals than the Executive resolution implied, and gained a large measure of support, and the SMA proposed an industrial health service, action on which was to be followed by the Labour Party with the TUC. A variety of opinions existed on the role of private practice and voluntary hospitals, but the SMA's strongly held opinions against both were widely supported.

Following the Conference, initiative was resumed again in July by the Public Health Sub-Committee, which now asked the Party Executive to consider sending a deputation to the Minister of Health with the Party's newly-ratified health policy. They noted their satisfaction with press comment on the policy, and with the wide distribution of the pamphlet "A National Service for Health," and they began plans for a national campaign including educational conferences to build a base of popular support for Labour's new policy. To complete that policy, the Committee approved draft statements on mental health and an industrial health service, but declined to prepare a statement on medical education, concluding that this would end their work until the publication of the government's White Paper on medical services, then expected in the autumn.

Resuming work in November 1943, the (renamed) Public Health Advisory Committee considered a number of refinements of Conference policy proposed formally by the SMA, which had several members on the

Committee. (21) The SMA recommended that the Party's policy be made explicit in four areas:

1. The need for unitary control of a fully integrated health service
2. The danger of extending the panel system of general practice
3. The need to end the dual hospital system; in particular the Party should dissociate itself from the expected government pledge to retain voluntary hospitals
4. A declaration in favour of Health Committees in factories, to function as sub-groups of the (wartime) Joint Production Committees and to operate via TUC machinery

Expanding on the reasons for a unified hospital system, the SMA said that conditions of admission of patients must be standardised and independent voluntary hospitals would continue to be selective about the cases they would accept; equally, medical education must be co-ordinated and standardised among all appropriate institutions; building and modernisation must be planned for all hospitals in a co-ordinated fashion; likewise, the distribution of specialist services and research must be rationally planned.

Difficulties over an industrial health scheme arose again at this time. On the fourth point, factory committees, there was disagreement between the SMA and the TUC representatives, who were concerned about control of the committees.

The SMA, in its resolution submitted and withdrawn at the Party Conference, had called upon the government to provide forthwith a complete Industrial Medical Service, in addition to urging the labour movement to press for elected factory health committees to work with the TUC. These committees, the SMA argued, should be specialised and

concerned with the enforcement of existing health and safety regulations, with advice and education on safety, optimum working hours, ventilation, canteens, rehabilitation and regular medical examinations; they should be democratic, including elected factory workers; and they should not be imposed from outside, as the TUC representatives appeared to misinterpret the SMA proposal. The SMA hoped the TUC's concerns would be satisfied if the committees were established as subsidiary to Production Works Committees, operating through TUC machinery.

This disagreement over industrial health policy was only a small indication of the lack of unanimity on the question among the SMA and the TUC, the Ministry of Health and the Ministry of Labour, and of the shades of opinion in the Labour Party, even though most agreed it was an urgent priority. The issue was to come up at later points in the evolution of the NHS, especially with Aneurin Bevan as Minister of Health, who had frequently been in disagreement with the TUC leadership. For the next year, until discussions began on the 1944 White Paper, the development of Labour Party policy, in conjunction mainly with the TUC, was a relatively smooth process.

Trades Union Congress Activities Before the White Paper

The TUC began developing policy on health services from July 1941 as it prepared evidence for submission to Beveridge's Interdepartmental Committee. This it did in collaboration with the Labour Party and the Co-operative Union, with the expert assistance of a TUC member-union, the Medical Practitioners' Union. The General Council of the TUC appointed its Joint Social Insurance Committee and Workmen's Compensation and Factory Committee (hereafter abbreviated JSIC) to be

responsible for inviting submissions from concerned trade unions and drafting TUC policy. The TUC maintained direct contact with Arthur Greenwood, Chairman of the Parliamentary Labour Party, who had responded to TUC pressure in having the Beveridge inquiry established.

From August 1941 the JSIC heard detailed proposals from the Medical Practitioners' Union on priorities in reorganising the health services. By mid-August, the JSIC had formulated nine areas on which recommendations would be made under Beveridge's general terms of reference, including a "comprehensive State Medical Service covering everything that medical science can command for the prevention and cure of sickness ... available to everyone in the State." (22)

When the committee next met in October, it was noted with concern that the general principles of a state service agreed upon would mean a drastic alteration or perhaps abolition of the Approved Societies, many of which were maintained by trade unions. Late in 1941 and early in 1942 the TUC-JSIC committee met with the Labour Party's Social Insurances, Assistance, and Family Allowances Sub-Committee and the Co-operative Union to consider points to be submitted jointly to Beveridge. The Labour Party group was delegated to prepare discussion documents on a national medical service and social insurance; accordingly, the Labour Party submitted papers, "A Scheme for a State Medical Service" and "The Health Centre in the Organisation of Medical Services."

In January 1942 the General Council met with the Interdepartmental Committee on Social Insurance and Allied Services, to present to Sir William Beveridge the views of the TUC. The exchange was a preliminary one, with Beveridge submitting a list of questions on TUC priorities for

further consideration. In March 1942, the government's commitment to a new hospital policy, outlined in speeches by Health Minister Ernest Brown, was noted in the TUC committee as a likely priority for Beveridge. Both the TUC General Council and the Association of Trade Union Approved Societies had by now come to the view that the approved society system of insurance administration must be abolished in favour of a uniform system, with uniform benefits. This position, submitted to Beveridge in August, was in accord with that of all other trade unions submitting views individually. The TUC reiterated its support for Labour's proposals for a comprehensive state health service.

The TUC held conferences in the major cities in the late summer on its social insurance and health service recommendations. Response was sufficiently enthusiastic that it was decided, upon publication of the Beveridge Report, to hold meetings nationwide, similar to those the Labour Party and co-operative movement were planning, to popularise health service proposals.

Sir William Beveridge met personally with the JSIC and the General Council on 9 and 16 December 1942, after publication of his Report, for a general discussion of its implications. This was followed almost immediately by a decision of the social insurance sub-committees of the TUC, Labour Party and Co-operative Union unanimously in favour of accepting the general principles of the Report, subject to further examination of details. (23)

Discussion began early in 1943, in light of the Labour Party's detailed documents, and the MPU memorandum, "The Transition to a State Medical Service." The MPU was assured by the TUC of representation on any TUC deputations to the Minister of Health following complaints to

the General Secretary of the TUC and to the Minister by the aggressive Dr Alfred Welply, Secretary of the MPU, that his organisation had been neglected in any such representative capacity.

In February 1943 the National Council of Labour, the highest body representing the TUC, Labour Party and Co-operative Union, met twice to consider the Beveridge Report. The later meeting followed the split in the House of Commons between the Labour Ministers and backbenchers. Both Arthur Greenwood and Clement Attlee attended, the latter making the point that the Parliamentary Labour Party had not understood the extent to which the government had accepted Beveridge's recommendations. The General Council passed a vote of confidence in the Ministers, and decided the parliamentary crisis had been "unjustified". (24)

Between March and May 1943, the tripartite Labour, TUC, and Co-operative social insurance committees were considering policy aimed at producing a joint resolution for the Labour Party Annual Conference in June. The resolution originally drafted by the Labour Party Public Health Sub-Committee (the one finally passed by the Labour Conference) was approved one month before the Conference. One noteworthy aspect of the resolution was its partial similarity with the BMA proposal that Regional Authorities be responsible for the health centre practitioner and ancillary medical and social services. The MPU intervened here in support of the medical profession's antipathy to lay control, however, arguing, along with the BMA, for a medical majority on all health service bodies at regional and lower levels. Doctors, the MPU felt, would not work under existing local authority arrangements or under their Medical Officers of Health. Labour Party representatives raised strong objections to this effective medical veto, but the disagreement

was not at that time resolved. Dr H.B. Morgan, physician to the TUC, presented a memorandum, "State Medical Service," to the joint committee in March 1943, supporting in detail all of Beveridge's arguments in Assumption B, and suggesting attractive conditions of service for all employees, with national Whitley machinery; and the democratisation of hospitals, in particular regarding voluntary hospitals as national, not private institutions. He emphasised integrating a preventive approach in the service, with expanded applied medical research.

In July, following the directive of the Labour Conference, the issue of industrial health policy was added to the joint committee's work. Again the material prepared by the Labour Party Public Health Sub-Committee was adopted jointly and included in a revised Party pamphlet, "National Service for Health," intended for wide public distribution. (25)

By October, the committees were moving from general principles to more detailed considerations of the structure of a health service. A lengthy memorandum was discussed, emphasising the interest of working people in socially equal access to services and medical education; occupational and environmental illnesses and those associated with industrialism and poverty; and democratic control of the distribution, range and quality of service.

"Health," the memorandum declared, "is frequently the workers' only asset, and on its unimpaired continuance depends his livelihood, economic position and the stability and happiness of his home, and that of his dependants." Thus full rehabilitative and preventive services must be provided. Industrial health should be integrated into all levels of medical education and research, along with social and environmental

issues; an integrated industrial medical service should be set up covering factories, small firms and shops, and linking these with community practitioner services. (26)

The memorandum voiced regret over the government's pledge to retain voluntary hospitals; this would prevent unification and impede co-operation and equality of access to hospital care. The memorandum recommended that practitioner and public health services be provided from local authority-run health centres, financed from the rates, and have all necessary staff for examination, diagnosis and treatment. The staff, including medical staff, would be all full-time and salaried. Preventive and health education functions would be part of the health centre service. A key to success in attaining a high quality service would be good conditions for all employees: security, professional advancement, promotion, study and travel, freedom to publish professional observations and opinions, full communication with hospitals treating the centre's patients, and free choice of doctor as far as possible.

Based on this memorandum, a brief statement was prepared and sent in October 1943, as a first summary of TUC recommendations, to Health Minister Ernest Brown. (27) The TUC's request to send a deputation was deferred by Brown, pending the White Paper.

The disagreement in the joint committees with the MPU over local medical control persisted until December 1943, when a compromise was reached: there should be no medical veto over local authority health decisions, but Local Medical Advisory Committees could appeal to the Minister and could publish their views in event of a dispute.

This agreement ended the work of the joint Labour, TUC, and

Co-operative health policy committee for 1943.

The Medical Practitioners' Union

The Medical Practitioners' Union had been active independently, outside the joint committee, in publishing its recommended health service policy. Its major memorandum, "The Transition to a State Medical Service," was issued in August 1942, and sent to the Minister of Health. In addition to the general principles of the service -- comprehensiveness, universal coverage of all the population for all medical risks, prevention, rehabilitation, research, no financial penalty -- with which the MPU was in agreement with the SMA, Labour Party and TUC, the memo made more detailed administrative proposals. It put much emphasis on ending the twelve Emergency Medical Service regions in favour of a system based on local authorities, single or combined depending on population, and using local authority democratic machinery to administer the comprehensive service, with central government standards and supervision.

The general practitioner service would be much improved through salaried practice. While private practice would be allowed to continue, the state service would be whole-time and salaried, with regularised salary grades, allowances, paid study leave and holidays, pensions, compensation for loss of "goodwill" on entering the service, and other benefits. The state service thus would be expected to be superior in every respect for doctors and patients.

Perhaps the most radical of the MPU policies concerned hospitals. First, the MPU recommended the nationalisation of all hospitals by the Ministry of Health, to be administered by the local authority structure.

Voluntary hospitals, including all property, assets, and investments would be taken over, along with municipal hospitals. Private wards would be abolished, except on a small scale for medical need. A new administrative structure, standardised hiring policies and conditions of work for staff, salaried consultants, and co-ordination of the special functions of certain hospitals within the areas would be features of the new hospital service.

The MPU was concerned, too, with medical education as a part of remodelling health services. The Ministry, not just the profession, should supervise all aspects; teaching should be broadened to encompass former municipal hospitals; universities and the Royal Colleges would be subsidised for participation in teaching programmes; and a single state examination would be the only necessary qualification for appointments. These features would be common to dental and nursing education also, and would have the effect of standardising entrance procedures, teaching programmes, and qualifications, for all medical schools.

The general principles of free choice of doctor and professional freedom in medical practice were stressed, and were seen, contrary to the BMA's view, as not at all incompatible with a state salaried service. The MPU made detailed proposals for the reorganisation of local public health and environmental services. It also emphasised that in a co-ordinated service, hospitals should cease to be the foundation and focal point of treatment as they had been in the past. In the new service, hospitals could be rationally organised into a scheme of central, district and specialist institutions co-ordinated with a well-organised general practitioner service. They need no longer be the place of first resort for treatment for large numbers of people, their

outpatient departments could be linked with the health centre practitioner service, and the interests of both medical efficiency and economy could be served in the process.

A request by the MPU to send a deputation to the Ministry was turned down, pending publication of the White Paper; the MPU then directed its attention in 1943 to the work of the TUC, Labour, and Co-operative joint committee.

The Socialist Medical Association

The SMA's activities preceding and following the Beveridge Report were not limited to aiding the Labour Party formulate its health policy. Through 1941 and 1942 it continued its publicist activities. In 1940, the Association's journal had published a detailed scheme for a socialised health service, based upon the general principles of universality and comprehensiveness which it had earlier propounded. It offered some detailed suggestions, again those for which it was well known, prefaced by a comment on the general political significance of its position:

A completely socialised medical service will be possible only in a completely socialised community; yet there is no reason why medicine should not be in the vanguard of the march forward, based as it is on service and imbued with altruism, and no reason why it should not be an example of the benefits to be derived from State organisation. (28)

The emphasis was on making available to all persons, without financial barriers, the best of modern scientific medicine, in all aspects, and in an efficient national service, with maximum freedom of choice for doctor and patient and democratic administration.

Two years later, in 1942, MEDICINE TODAY AND TOMORROW printed again the SMA programme, in light of the British Medical Association's "Draft Interim Report of the Medical Planning Commission." The Report was criticised for its failure to break with certain strongly-held orthodoxies of the medical profession, in particular that the wealthiest ten per cent of the population should be excluded from a public scheme in order to benefit the private medical sector. Again the structure of a socialised service was set out, with stress placed on health centres as the base for general practice and public health, on an industrial health service, and on wide reforms to democratic medical education. Suggestions for the transition from the Emergency Medical Service to a comprehensive state service were made. (29)

Also in 1942, Dr David Stark Murray published for the SMA, in book form, a popular account of the SMA's position on why Britain should have a state health service, and the form it might take. (30) The SMA journal approved of Beveridge's linking, in his Assumption B, of health and social security measures in interdependent relationship, and his suggestions that general practice, reorganised in health centres in the context of a comprehensive service, would provide the basis for the necessary co-operation between state and citizen in the maintenance of health. (31)

Following the release of the Beveridge Report, the SMA stepped up its activities in both the public advocacy and the policymaking spheres. Public meetings were held in many places. In March 1943 an SMA deputation met with Minister of Health Ernest Brown to put forward the Association's proposals, and followed up by sending a number of the SMA's policy documents to the Ministry. The annual meeting of the SMA,

in May 1943, gave formal approval to Assumption B, noting it could only be fulfilled by the establishment of a socialised health service. This position was elaborated at the Labour Party Conference in June by Mr Somerville Hastings, who argued forcefully for those features of the SMA's policy which distinguished it as a socialist scheme, in comparison with the more conservative proposals of Beveridge.

In October 1943 an SMA conference, under the title "A National Service for Health," with some 200 delegates from professional, co-operative and trade union groups, endorsed Beveridge, and requested of the Minister immediate implementation of the health service proposals. This followed the "London Conference on Health" in February, and a Health Workers' Convention in May 1943. (32)

In November 1943 the SMA again requested to send a deputation to the Minister; the request was turned down in favour of a postponement until after the White Paper had been released. Meanwhile, a deputation was received in November by the Lord President of the Council, the Rt. Hon. Clement Attlee, one of the three Labour Cabinet Ministers. The SMA's views on the urgency of action, and on basic principles of universality, unification of hospital systems, administration by enlarged local authorities, and free, tax-financed services, were put forward, in the context of the government's apparently weak commitment to implement Beveridge, and the Labour Party's conference policy which the SMA had had a large part in framing. Mr Attlee's reactions to the SMA deputation are not recorded.

SMA membership in 1943 had grown rapidly to 1,500. While many of these were professionals, the Association attempted to involve, through leaflets, meetings, and the health workers' conferences, as many persons

from other health service occupations as possible; this attempt was reflected in its rapid membership growth. The SMA aided also in the distribution of the Labour Party policy material.

All these efforts were geared to the widest distribution and discussion of the state medical service proposals of the SMA and Labour Party. In several respects 1943 was an ideal time for such activity -- after the immensely popular but relatively general Beveridge proposals, and before the government made definite proposals of its own in the anticipated White Paper.

The BMA incurred criticism from the SMA in 1943. While the BMA had earlier tentatively endorsed the Beveridge recommendation for a comprehensive health service, its Annual Representative Meeting, with support of its Council, now voted for a resolution calling for health service coverage for only ninety per cent of the population, for the right of health service doctors to do part-private practice, and for the retention of sale and purchase of practices. The SMA saw this as a volte face from the BMA Council's decision on the Draft Interim Report of the Medical Planning Commission, and was prompted to comment that "the BMA is not concerned with general principles nor with the health of the community or the individual, but only with the incomes of the doctors."

(33) The lines were thus beginning to be drawn on several major issues of principle concerning the structure of the health-service-to-be: coverage of all the population, private practice, and the sale and purchase of public practices. The two medical associations were in battle, if not directly against each other, certainly for the principles and interests most fundamental to their membership and following. The SMA, says Dr Stark Murray, "clearly saw that it had to influence the

medical profession as much as possible but it also had to make the public so convinced of the need for a national health service that nothing would be allowed to stand in its way." (34)

The Position of the Advocates by Late 1943

There had developed by this time a certain division of opinion within the Labour Party over support for the SMA's 'socialist' model health service, implying full state ownership of facilities, salaried medical practice, and fully integrated, preventive industrial health services, as part of a thoroughgoing and immediate reorganisation of the social organisation of medicine. The opposing body of opinion, which was less articulate and organised, but nonetheless significant, since it was based in the Parliamentary leadership and the National Executive Committee, argued mostly on grounds of political expediency against too rapid a changeover, and against nationalisation of voluntary hospitals. The compromise was to propose the "incorporation" of the voluntary hospitals, which might have meant a scheme of voluntary, subsidised co-ordination. Significantly, the 1943 Party Conference supported whole-time salaried service for doctors, and the establishment of health centres.

The TUC, by the end of 1943, had resolved the issue of the probable demise of the trade union approved societies, if a national health service were to be created. Its concerns were equally that the service address comprehensively the social and industrial bases of ill-health and that, internally, it should provide adequate and attractive conditions of work for all grades of employees, and for democratic organisation of health workers. While it was quite prepared to endorse

most of the Labour Party - SMA proposals including the nationalisation of voluntary hospitals, it was apparently wary that the SMA's proposals for industrial health committees would involve too little trade union representation. This the SMA denied. It was, however, at one with the SMA in strongly advocating an industrial health service, a point which the Labour Party NEC declined to include in its 1943 Conference resolution, but was willing to amend later.

The MPU was in agreement with, or expressed stronger views than, the other bodies on most general issues: it strongly supported the nationalisation of all hospitals, along with the abolition of private wards; it urged an entirely salaried basis for medical practice, which it argued was not at all incompatible with free choice of doctor; and it argued for the reorganisation of general practice in health centres, so that hospitals would be primarily for referral, and no longer the focal point of the medical system. It advocated far-reaching reforms to democratise medical education. The MPU's main point of difference with the other advocate groups was in the extent of local authority control over the regionalised medical administration, an important element in their model service. Here, agreement was reached by the end of 1943, which satisfied the MPU's concern for medical freedom.

All the advocate groups, separately and jointly, had approached the Coalition government with their views, particularly after the release of the Beveridge Report. They interpreted their task as the double one of supporting Beveridge because of the enormous popularity of his proposals, but critically, since he provided few details for the construction of a health service. On the other hand, they had to prepare such detailed blueprints, and inject them into both popular

discussion and government planning. Apart from Health Minister Brown's few pronouncements, and his suggestions to the advocates that no further submissions or deputations be sent until after the publication of the White Paper, expected near the end of 1943, the government's response was not yet clear.

CHAPTER 4 -- FOOTNOTES

1. Labour Party, Public Health Sub-Committee (PHSC), R.D.R.8, October 1941.
2. Labour Party, PHSC, R.D.R.37, December 1941.
3. One abuse for which voluntary hospitals had been faulted was their policy of choosing patients with short-term ailments or with conditions of interest to medical students, and rejecting those with long-term and chronic conditions, whom the municipal hospitals were obliged to take.
4. Labour Party, PHSC, R.D.R.44, December 1941.
5. Labour Party, PHSC, R.D.R.99, May 1942.
6. Labour Party, PHSC, R.D.R.154, December 1942.
7. Labour Party, Social Insurance Sub-Committee, R.D.R.158, December 1942.
8. Labour Party, Social Insurance Sub-Committee, R.D.R.194, February 1943.
9. Calder, THE PEOPLE'S WAR, p. 613. In particular, the government would not agree to the transfer of industrial insurance to the state, or to the immediate establishment of a Ministry of Social Security. Labour Party, Annual Report, 1943 (London: Labour Party, 1943), pp. 70ff.
10. Labour Party, Annual Report, 1943, p. 115. See also Alan Bullock, THE LIFE AND TIMES OF ERNEST BEVIN, II, MINISTER OF LABOUR 1940-1945 (London: Heinemann, 1967), pp. 226-235, for a discussion of the reception by the Cabinet of the Beveridge Report, the debate on it in Parliament, and the role of the Labour Ministers.
11. Labour Party, Annual Report, 1943, p. 136; THE TIMES, 16 June 1943, p. 8, col. 1.
12. Aneurin Bevan MP, "Labour Must Stay in the Government," TRIBUNE, 5 March 1943, pp. 6-7.
13. Aneurin Bevan, "Open Letter to Any Labour Delegate," TRIBUNE, 11 June 1943.
14. "Labour's Future Policy," THE TIMES, 15 June 1943, p. 8, col. 1.
15. Aneurin Bevan, "Coalition of the Left," Editorial, TRIBUNE, 18 June 1943, p. 6.
16. Labour Party, Agenda for the 42nd Annual Conference (London: Labour Party, 1943).

17. Labour Party, Agenda, 1943.
18. Labour Party, Annual Report 1943, p. 5.
19. Labour Party, Annual Report 1943, p. 145.
20. THE TIMES, 16 June 1943, p. 8, col. 1.
21. From 1941 until the landmark policymaking Conference of 1943, the normally-titled Public Health Advisory Committee (of the National Executive Committee) operated under the name of Public Health Sub-Committee, a change of slight significance, except insofar as it indicated a general change in constitution of the Party's policy advisory structure for purposes of drawing up comprehensive postwar economic and social reconstruction proposals. With a wide overlap of membership, some ex officio and some nominated, the Public Health Sub-Committee was the lowest in a three-tier structure under the Social Services Reorganisation Committee which was to co-ordinate the work of the Public Health, Housing and Social Insurance Sub-Committees for the Central Committee on Reconstruction Problems, which in turn reported to the NEC.
22. TUC, Joint Social Insurance Committee and Workmen's Compensation and Factory Committee (hereafter abbreviated JSIC) Minutes, 13 August 1941, 10 August 1941.
23. Beveridge Report, p. 34, paras. 74-76. TUC, JSIC Minutes, 9 December 1942; General Council Minutes, 16 December 1942.
24. TUC, National Council of Labour Minutes, N.C.L. 10, 1942-1943, 23 February 1943; General Council Minutes, 24 February 1943.
25. Labour Party, "National Service for Health," April 1943, revised and reprinted September 1943, 23 pp.
26. TUC, JSIC Memorandum 1/1, "On a National Medical Service," October 1943, 15 pp.
27. TUC, JSIC Memorandum 1/2, "National Medical Service," 20 October 1943, 2 pp.
28. "Scheme for an Immediate Socialised Service," MEDICINE TODAY AND TOMORROW, 2, No. 7 (September quarter, 1940), pp. 2-16.
29. "The Socialist Programme for Health," MEDICINE TODAY AND TOMORROW, 3, No. 7 (September quarter, 1942), pp. 3-17.
30. D. Stark Murray, THE FUTURE OF MEDICINE, (Harmondsworth: Penguin, 1942).
31. "Freedom from Want -- The Health Basis of Social Security," Editorial, MEDICINE TODAY AND TOMORROW, 3, No. 8 (December quarter, 1942).

32. D. Stark Murray, WHY A NATIONAL HEALTH SERVICE?, pp. 60-64.
33. Editorial, MEDICINE TODAY AND TOMORROW, 4, No. 3 (September quarter, 1943).
34. D. Stark Murray, WHY A NATIONAL HEALTH SERVICE?, p. 63.

CHAPTER 5

GOVERNMENT PLANNING AFTER BEVERIDGE:

HEALTH MINISTER BROWN, THE MEDICAL PROFESSION

AND WIDER CONSULTATIONS

The political consensus had clearly shifted in the first half of the war toward acceptance of massive permanent state intervention. While the Coalition cabinet was, of course, heavily weighted toward the Conservatives, with only three Labour Ministers, there were, however, differences of opinion among the Conservatives which, between 1943 and 1945, were to be very important in the shaping of parts of the health service.

Calder comments on the political context in which the Coalition began to act on the Beveridge recommendations and in which it began, in its reconstruction plans, to construct a continuity in state economic and social activity, from wartime to the postwar world:

From the consensus which was now developing sprang the ideology which was to govern the practice of both parties in office after the war. Capitalism, and with it a system of powerful private interests, must be preserved; but the state would take a positive role in promoting its efficiency ... In effect, this consensus included the whole centre of British political life. (1)

Even as the stormy debate in Parliament was taking place in February 1943, over the government's apparently ambiguous commitment to Beveridge's particular recommendations, and as Beveridge was being banished from any further role in implementing his scheme, officials of

several departments, under the direction of Cabinet, were at work taking the initial steps to shape legislation.

Indeed, Ernest Bevin, as Minister of Labour, strongly impressed with the importance of health in industrial production, had instructed his officials as early as April 1942 to draw up plans for the postwar continuation of the Factory Medical Service and the Industrial Health Research Board. The assumption was that they would continue to be part of the Factory Department of the Ministry of Labour. Bevin's biographer admits it is not clear why he wished these medical schemes to remain under the Ministry of Labour rather than the Ministry of Health.

A year later, in March 1943, Bevin again took the initiative in industrial health with the appointment of a twenty-seven member Industrial Health Committee, with medical, trade union and employers' representation, and himself as Chairman. In April he attended, with the Minister of Health, a large conference on industrial health. According to Bullock, Bevin's object "was to put industrial health on the map and to give it as wide an interpretation as possible, covering not only factory medical and nursing services, but medical research, the design of buildings and machinery, communal feeding, and personnel management."

(2)

In the Conservative Party, a group of fifty young MPs, convinced of the appropriateness of state intervention, and, unlike some of their colleagues willing to defend Beveridge, constituted itself the Tory Reform Committee. This group, led by Quintin Hogg, among others, continued to share with the Labour Ministers, particularly with Herbert Morrison, an affinity for pragmatic, rationalising economic and social measures, including some nationalisation.

In March 1943, Churchill, with evident reluctance and conspicuous omission of any reference to Beveridge, made an important broadcast to announce a Four Year Programme of "five or six large measures of a practical character" including "national compulsory insurance for all classes for all purposes from the cradle to the grave," in addition to full employment, state aid for farmers, a National Health Service, equal opportunity in education, and a "broadening field for state ownership and enterprise." This was to usher in a two year period of planning and discussions resulting in what Sir William Beveridge dubbed the "White Paper Chase," prior to the enactment of the last major legislation of the Coalition and the first of the 1945 Labour government. (3)

The War Cabinet Approves Brown's Preliminary Plans

During February, the Reconstruction Priorities Committee of the War Cabinet gave consideration to the first detailed plan for a national medical service. The proposals were contained in the memorandum prepared jointly by the Minister of Health, Ernest Brown, and the Secretary of State for Scotland, Thomas Johnston. The memorandum was concerned mainly with the structure of the service, and based on the paramount principle that "the comprehensive health service must be one and indivisible in each area of the country." The logic of this was that, if local authorities were not to be deprived of their existing services, to which there would be much objection, they should be in charge of the entire service, which could be achieved by combining local authorities into regional units of roughly similar size and amalgamating their health functions as joint health authorities. Careful negotiations with local authorities would be necessary, and with the

medical profession, which would have to be given adequate representation on the joint authority health committees, to assuage its extreme fear of local authority control. Voluntary hospitals would be brought into the scheme by subsidised, contractual arrangements with the joint authorities. The status of teaching hospitals, and the question of whether to make them central to the hospital services in each joint authority area, were seen as debatable, as was the recovery of hospital costs from patients, as recommended by Beveridge.

The health centre concept was seen by the Ministers as a desirable way of reorganising general practice, with the proviso that competitive private practice and freedom of choice of doctor must be preserved. For young doctors entering the service, however, the Ministers had "no doubt that they should be under an obligation to give full-time service."

A reorganised general practitioner service was crucial to the overall scheme; it was a matter of great urgency to arrive at a policy to present to young doctors leaving war service, so that they could be taken directly into the new system before having to make interim arrangements. The Ministers proposed eight main features of the new general practitioner service:

1. Administration by the single health authority in each area
2. Coverage of all persons, there being "no ground on which exclusion could be justified" in a publicly funded service
3. Optional private practice for doctors and patients and part-private practice for doctors
4. Supervision of the quality of medical services by the joint health authorities -- the panel system under National Health Insurance exercised little such control
5. The profession's fear of lay control should be met in three ways: (a) a central Medical Advisory Committee with parallel regional groups, to advise the Minister; (b) medical representation on the local health authorities; and (c) a

Central Medical Board to oversee professional affairs and safeguard individual members, and to recommend and ratify medical appointments

6. In hiring practitioners, local health authorities would make the final selection from a short list provided by the Central Medical Board; the "protected tenure" system would end
7. Payment to doctors was seen as a difficult matter, the BMA attaching much importance both to competition for patients and free choice of doctor with which it believed only the capitation system to be consistent; the Ministers saw no logical connection between free choice and method of payment, preferring payment by a merit system, especially in health centres where a reasonable salary scale with superannuation could operate
8. The gradual implementation of a comprehensive service, in several stages, was rejected in favour of full application of the scheme, with due consideration to adaptations necessary for doctors already in practice. (4)

By the time of the House of Commons debate on the general principles of Beveridge, in mid-February, the War Cabinet Reconstruction Priorities Committee had agreed on several fundamental principles:

1. The service would be comprehensive, i.e., covering all aspects of medical care
2. It would be universal, covering all the population. Here the Committee notably rejected BMA arguments for a 'ninety percent scheme', i.e., excluding the wealthiest ten percent of the population
3. There would remain scope for private medical practice
4. Voluntary hospitals would continue
5. It would probably take several years before full dental and ophthalmic services could be included
6. Detailed negotiations with the medical profession and other interests should begin at once. (5)

These principles were announced in the Commons February 16 by the Lord President of the Council, Sir John Anderson, in Prime Minister Churchill's absence. No commitment was made to early legislation. There would first be confidential discussions with the medical profession and health authorities, a White Paper would be prepared for public

discussion, and finally the plan would be drafted in the form of legislation. (6)

This procedure was, in general, followed over the next two years, although not even the year of discussions after the White Paper of February 1944 saw the drafting of legislation accomplished before the dissolution of the Coalition in May 1945, the brief interregnum of the Conservative Caretaker government, and the dramatic election of July 1945.

Brown's Initial Discussions: The Local Authorities

Discussions with the medical profession, the voluntary hospitals, and the local authorities did indeed begin in March 1943, and were reported upon by the Minister of Health to the War Cabinet Committee on Reconstruction Priorities in July. (7)

The local government organisations represented in the first discussions were the County Councils Association, the Association of Municipal Corporations, and the London County Council (LCC). The discussions focused on the government's proposal that local authorities should be grouped into health regions and joint health authorities formed to administer all branches of the comprehensive service. The local government representatives made two major points: local authority 'clinic' services would be better run by individual rather than grouped authorities; and there was a need for a general review of the future functions of local government.

Other local government groups were also consulted: the non-county borough councils, urban and rural district councils, and the London metropolitan borough councils.

The Minister recorded his preference for the original (February) proposal for a service with all branches unified under combined or joint local authority auspices, and accordingly prepared a plan showing forty-two such areas. He argued the case for placing the general practitioner service under the new joint authorities on two grounds: the need for unification of services; and the likelihood that the medical profession would "summarily reject" the practitioner service being placed under existing local authorities, considering their traditional antipathy to local authority public health arrangements. The Minister also argued, on the same principles of unification, for placing the clinic and welfare services of the individual local government units under the new joint authorities. To ensure equity in the delegation and sharing of functions among the various hospitals participating in each area, he recommended the creation of district committees representing the joint authority, the medical profession, the individual councils, and the voluntary hospitals. It appeared that, although the Minister's recommendations of unification of all functions under joint authorities ran counter to the wishes of the local authority organisations, he did not expect strong opposition from them.

Initial Discussions: The Medical Profession's Reaction

Discussions with the medical profession did not proceed as smoothly. The BMA first appointed a Representative Committee of thirty-five members with the understanding from the Minister that the purpose of the consultation was to discuss, not to negotiate. After initial meetings, the Representative Committee requested that the government put in writing some of its ideas, particularly for the system

of group practice in health centres, and for proposals regarding terms and conditions of service, including remuneration and compensation for the loss of value of practices. According to Eckstein, "the medical delegates had asked the Ministry what a salaried service for general practitioners might be like; the Ministry had responded by producing a plan which it was willing to discuss but to which it apparently attached no authoritative weight." (8)

Wilson Jameson (later Sir), as Chief Medical Officer at the Ministry of Health, was one of several Ministry doctors, whose function it was, since they had no executive powers, to "fly kites" in the talks with the medical profession, that is, to advance proposals unofficially. Jameson accordingly outlined the hypothetical details of a salaried scheme, worked out by the Ministry, to the Representative Committee. (9) Although the discussion was understood to be confidential, according to the Minister's memorandum of 28 July 1943, distorted and sensational reports of it were leaked to the press. Dr Hill, Deputy Secretary of the BMA delivered an "intemperate speech" to a mass meeting of doctors in London, 16 May 1943, purporting to reveal the government's firm proposals to be: fully salaried public medical work; general practitioners practising in health centres with the right to private practice; all medical services to be run by local authorities; and specific figures for the salary scale. The BRITISH MEDICAL JOURNAL reacted immediately, angrily accusing the government of an attempt to turn the medical profession into a "service of technicians controlled by central bureaucracy and by local men and women entirely ignorant of medical matters." (10) The impression given to the mass meeting, Eckstein notes, was that the BMA Committee had been presented with a

fait accompli by the government, which would reduce the profession to the status of local government functionaries.

The Minister was obliged to respond in the House of Commons with an explanation of the course of events.(11) The BMA called for a Royal Commission, a tactic which Eckstein interprets one of obstruction: "As soon as the government became serious about reforming the medical system, a sort of nameless fear of what might ensue gripped the profession's representatives." (12)

As a result of these events, Brown approached the BMA to appoint a smaller committee to continue discussions. This was done, and the positions were clarified in the Minister's memorandum to the War Cabinet of 28 July. Three areas were explored: central administration; local administration; and the general practitioner service.

1. Central administration. The BMA Committee proposed the health service be operated not by the Ministry but as a semi-independent medical commission. The Minister felt the BMA would be unlikely to pursue this matter, since a commission would in effect be similar to a government department. The BMA secondly proposed placing the health functions of all government departments under the Ministry of Health, including the school medical service, the factory medical service, the mental hospital and mental deficiency services, and the police and post office medical services. While non-committal on this range of services, the Minister changed his previous position to agree that the mental health services should be included from the start, rather than awaiting their overhaul. Thirdly, the BMA approved the Minister's proposed Central Medical Board along with a Medical Advisory Committee which they felt should be strengthened and enabled to have an independent public

voice in case of dispute. The Minister felt this point should be conceded, in the interests of a more effective central administration.

2. Local administration. Substantial agreement was reached on medical representation on the proposed joint health authorities and on the role of local professional bodies.

3. The general practitioner service. Discussion here focused on the Minister's original proposals taken, as he noted, from the Draft Interim Report of the Medical Planning Commission (1942).

The basic proposal was for a health centre-based, salaried practitioner service, with superannuation and compensation for the lost value of private practices. The BMA now objected on four grounds to this idea: (a) it would mean that group practice would supersede competitive panel practice; (b) payment would be by salary; (c) private practice would be limited to those doctors already in private practice; and (d) the local health authority would be in charge of employing doctors and terminating contracts.

The Minister accused the BMA Committee of failing to honour the commitment to health centres contained in their 1942 report. "Hence, in the discussions, the Committee, while not wholly repudiating the conception of Health Centres, were at pains to suggest that at most the idea was an interesting one which might usefully be tried out on a small scale, and that throughout the country a system not unlike the present panel system would fill the bill." (13) The Committee argued the idea was untried, would take time to build, would be impractical in rural areas, and that the National Health Insurance panel system of capitation payments to practitioners was satisfactory. The Minister questioned the practicality of maintaining parallel systems of health centre and solo

panel-type practice.

On the second point, salaries, the Committee argued that capitation payments were the basis for a more personal relationship between doctor and patient. They did, however, endorse the view of the Medical Planning Commission report (which they were later to reject) that doctors in health centres should receive a basic salary, and that it was only the method of earning money above this amount that was at issue. The Minister reminded them that medical opinion on salaries would be divided, with more younger doctors in favour: "I do not doubt the opposition to a universal and compulsory system of salaries will be bitter and sustained. It is quite clear this opposition is being urged in the meetings of BMA Divisions." (14)

On the limitation of private practice, the Minister foresaw possible abuses of a part-time system, such as neglect of the public side of a doctor's practice and the possible deterioration of public practice. Since it appeared unlikely, however, that more than ten percent of patients would prefer private treatment, there would be no need to allow more than a small proportion of doctors to practise privately. The Committee agreed that young doctors might fairly be expected to practise full-time in the public service for a number of years: the Minister agreed, and suggested a five to seven year public service requirement.

On the matter of entry into the service, the Committee felt the Central Medical Board should be responsible for appointments and dismissals, a position to which the Minister acceded. His proposal was that, with the local health authority advising the Central Board on appointments, a system of tripartite contracts among the practitioners,

the health authority and the Central Medical Board should be arranged. This should, he felt, allay the profession's fears of local authority control and reflect the reality of dual employing agencies.

With respect to the evident maldistribution of doctors in the country, the Minister noted to the Cabinet the obvious need for some procedure for allocation of doctors, particularly in industrial and isolated areas. He felt the profession would not be strongly opposed to some such mechanism. The consequence of regulating the location in which doctors might practise would, however, imply the end of the system of sale and purchase of medical practices, at least among doctors in the health service: "The sale and purchase of panel practices has for long been something of a scandal, as many leaders of the profession have admitted." (15) Compensation for the loss of value to those who had already purchased their practice, and a superannuation scheme in the health service, would in his view be a logical means of recompense.

A further proposal to improve the quality of general practice was that practitioners should have full access to and consultation with the specialist and hospital services, and with welfare, school clinic, and other social services.

Based on the tentative agreements reached in discussions with the BMA Committee and on his own proposals, the Minister therefore recommended several adaptations to panel practice including: allocation of doctors; ending sale and purchase; provision of basic salary and superannuation; controls over employment conditions for assistants; the establishment of medical boards for certification of doctors; and the linking of practitioner, specialist, and local authority public health and clinic services. These were perhaps the most contentious of Mr

Brown's proposals, those which later incurred the most determined opposition of the medical profession.

On the question of whether there should be a full-scale conversion to health centre-based group practice with the commencement of the comprehensive service, or a gradual transition, with health centres being built alongside competitive individual practices, the Minister reluctantly, it would appear, favoured the latter course. His abandonment of hope for immediate, full-scale conversion was due to the resistance being voiced at that time by the BMA and BRITISH MEDICAL JOURNAL to any large health centre development. The opposition, he hoped, could be overcome with experience. Thus, he suggested the government make clear its firm intention to re-establish general practice after the war on the basis of group practice in health centres. Subject to practical difficulties of building, they should give local health authorities wide discretion in establishing centres, and should ensure full consultation with local medical opinion. "But in the last resort the public interest must prevail, and it should be made plain that a right on the part of the local profession to veto the establishment of a Health Centre cannot be admitted." (16)

Discussions with the Voluntary Hospitals

The third group with which Mr Brown held discussions and reported in the 28 July memorandum was the British Hospitals Association (BHA), representing the voluntary hospitals. After several meetings, he recorded, their apprehensions of being placed "under" the local authorities were dispelled, and agreement was reached on several main points. The Minister agreed to their request for a central advisory

body and mixed local administrative bodies representing the voluntary hospitals in the area, the medical profession and the health authority. The health authority would draw up a plan determining the role of each hospital -- municipal and voluntary. Medical appointments would be, to some extent, centralised under the joint authority.

The Minister conceded to the strong representations of the voluntary hospitals and the hospital savings associations in agreeing to the Beveridge position that patients should continue to pay some part of the "hotel" costs of their stay, either directly or through a savings association. One pound per week was suggested. The associations would be required to achieve uniformity in their contributions and accounting, and apply their benefits to all hospitals. Finance of voluntary hospitals was also discussed, and general agreement reached on a formula for their partial funding from rates and from the Exchequer.

The 28 July memorandum concluded with comments on the difficulty of maintaining secrecy in discussions with the interested parties, and a strong recommendation for publication of a White Paper by the autumn of 1943.

The SMA and the MPU Petition Ernest Brown

The SMA had also been persistent in its approaches to Brown in 1943. In late February, following a meeting of the BMA Medical Planning Commission, Somerville Hastings of the SMA, supported by Labour Party Secretary J.S. Middleton, requested that Brown receive a deputation, either with the BMA's deputation of 9 March, or separately. Accordingly Brown met with the SMA on 26 March, having been briefed by his officials on the programme and on the background of some of the prominent members

of the SMA. The Minister outlined to the deputation the main principles the government would follow. This represented, in effect, the guiding principles upon which the government had made firm decisions. The service would be available to all, irrespective of means; it would aim at positive health and wellbeing; and it would be mainly free, with the possible exception of charges suggested by Beveridge. The service would be best located with local government, to ensure full public responsibility, while professional freedom and consultation would be guaranteed.

In turn, the SMA presented a memorandum to the Minister in essence similar to that prepared for distribution by the Labour Party following its 1943 Conference. It stressed a single unified service, division of the country into areas larger than individual local authorities, and the creation of health units consisting of co-ordinated hospitals and health centres for population areas of about 100,000. One health centre should serve about 20,000 people.

The SMA deputation welcomed the Minister's apparent acceptance of salaried general practice, and offered to submit to the Minister's announced sub-committee on health centres a detailed memorandum of SMA ideas. (Ministry documents show no further reference to this sub-committee.) They further stressed the unification of the hospital system -- making no reference to the means advocated -- and the desirability of keeping any private practice out of the state system, even though it might exist outside. They were particularly opposed to the capitation system in health centres, as introducing a destructive element of competition for patients; they did, however, emphasise that freedom of choice of doctor was as easily guaranteed in a salaried

system as with capitation, a position strongly opposed by the BMA. The BMA idea that capitation fees were an incentive to good medical work was dismissed as "plain nonsense."

In May the SMA sent the promised extensive memorandum on health centres, outlining numerous details of health centre services: population bases; co-ordination with hospital and specialist services; possible teamwork arrangements; integration of both health centre and district hospital work into medical curricula; high amenity standards of buildings; inclusion of dental and ophthalmic services; free choice by patients of doctors both within and between centres; and democratic control, both by health workers within the centre, and by adequate representation on the local health authority. (17)

These proposals were therefore before the Minister during the beginning of difficulties with the BMA. His response to the deputation is not recorded.

Not only the SMA approached the Minister directly in favour of a comprehensive service during mid-1943. The controversy with the BMA moved a number of trade union branches to write, urging the Minister to remain firm in his intention to implement Assumption B.

The Medical Practitioners' Union, having requested from March to be included in discussions, was, in July, finally invited to send a deputation to the Minister, despite the anticipation by Ministry officials of anger in the BMA at the MPU being given an interview. The MPU was described to the Minister by his officials as left wing but not necessarily associated with the SMA, and as the only significant body outside the BMA representing general practitioners. It was noted, however, that "those on the councils of the BMA have the strongest

dislike of the MPU and possibly fear that its aggressive policies may one day make it a truly rival organisation." The articulate opposition of the MPU to competitive private practice was noted, along with their advocacy of the inclusion, by transfer of ownership, of voluntary and municipal hospitals in one state hospital scheme, and of salaried general and specialist practice with appropriate expense allowances.

The deputation of ten, led by Dr Gordon Ward, introduced to Mr Brown several detailed MPU memoranda on aspects of health service policy, the most detailed of which had been prepared in August 1942. The deputation elaborated on some of its positions already known to the Ministry, and on some from its memoranda. Its proposals for a fully nationalised hospital system were explained, including the abolition of private wards, and the encouragement of voluntary work and of donations surplus to normal budgetary needs. The MPU's position in favour of whole time salaried practitioners and specialists was restated. Notably, also, it was suggested that the personal health or clinic services of the local authorities be split, with the maternity service and various clinics going to the new area health authorities, and home helps and health visitors remaining with the individual authorities -- a compromise similar to that ultimately chosen in the NHS. Reforms to democratise medical education were also expanded upon, as were the MPU's proposals for the reorganisation of general practice in a state service which would exclude any element of private practice inside the service, although it was not suggested to control private practice outside. It was assumed general practice would be grouped in a "central office," except in rural areas. It is noteworthy, however, that the MPU made no specific mention of the health centre concept as such, developed in

detail by the SMA. (18)

Reaction by the Minister and his officials to the MPU deputation and memoranda is not recorded in the Ministry documents. The MPU were to make no further representations before the 1944 White Paper.

Controversy in the House of Lords

A debate in the House of Lords, 2 June 1943, added more fuel to the fire of controversy over the implementation of Beveridge's Assumption B. Debate was on a motion by Lord Derwent that, since the Beveridge Plan did not appear to be in the best interests of doctors or the public, the government should not adopt its proposals without careful examination. Viscount Dawson of Penn, famous for his report of 1919 advocating a comprehensive service, now criticised the government for introducing a "spirit of haste and hustle, instead of proceeding gradually," and of "trying to build a structure in a few weeks time which was beyond the wit of man to do... The medical profession would not consent to be pawns on the local government chess board." Lord Moran, on a more positive note, stressed the need for unification of all services under one government department, but was against local government as an employing agency of doctors. For the government, Lord Snell reassured the Members that avoiding a hasty decision was precisely the policy being pursued, that no decision had been made on a salaried service, and that the profession was being consulted at every stage. The government had resolved there would be neither unreasonable haste nor unreasonable delay in building the service. (19) Lord Derwent's motion was withdrawn, but the attention attracted by the debate again raised public and news media doubt about the firmness of the government's intentions.

(20)

The War Cabinet Considers Brown's Revised Proposals

The War Cabinet Committee on Reconstruction Priorities considered the Minister's recommendations from the end of July to the end of the year. In the first meeting following presentation of the 28 July memorandum, health centre policy was discussed. (21) "Varying views were expressed on this point. Most Ministers thought that the supersession of the Panel system by group practice in Health Centres was the right course. The Chancellor of the Exchequer [Rt. Hon. Sir Kingsley Wood MP] favoured the continuance of the Panel system in an improved form." Some Ministers felt further consultation with the medical profession should precede any White Paper, lest their opposition be crystallised. It was agreed that the Committee would discuss the Minister's proposals in greater detail before taking any position on a White Paper. (22)

The subsequent meetings in August and September, on the role of local authorities, agreed that larger administrative areas than counties or county boroughs were required, and that the best proposal was that suggested in the Minister's 28 July memorandum, for combined or joint local authorities. Some Ministers registered objections on grounds of opposition by the medical profession and local authorities. (23)

At the following meeting, in mid-September, a disagreement surfaced between Mr Brown and the Labour Secretary of State for Scotland, Tom Johnston, who was responsible for planning the health service for Scotland, over responsibility for the general practitioner service. The Scottish Secretary argued that it should come under the central

authority, since Scotland already had successful experience with central administration of practitioner services. The Minister, on the other hand, put the case for unified local administration of all branches of the service by the joint local authority bodies. (24)

At this meeting issues concerning private practice were also discussed, the Minister agreeing to allow private practice outside the service by existing practitioners, and payment by capitation to solo practitioners. Significantly, he remained committed ultimately to salaried practice in health centres. He reiterated the need to restrict new health service practitioners to full-time public practice for their first few years of practice, and again urged the end of sale and purchase: "The right to buy and sell a title to public remuneration (i.e., the purchase of private practices) seems to me indefensible."

(25) The Minister again urged that a number of health centres be constructed without delay at the opening of the service.

The Minister and the Secretary of State for Scotland returned to the October War Cabinet Committee meeting on health services with a joint memorandum noting points on which they agreed and disagreed. They now expected that the practitioner service would be based on a continuation of panel principles with a gradual transition to group practice in health centres. But they noted that whatever the form of, or administrative authority for, the practitioner service, the principles of unification and co-ordination of specialist, practitioner, and clinic services were paramount; they specified several mechanisms by which such co-ordination might be attained. It was again reiterated that private practice should be limited, that sale and purchase of public practices should cease, and that public practices should be

distributed roughly according to population, by a Central Medical Board, using a "negative direction" approach, whereby "overdoctored" areas would be closed to new practices. The Board, the highest medical body within the service, would be appointed by the Minister, thus avoiding the "danger of the Board being composed of elderly doctors nominated by professional bodies who did not represent the more progressive sections of the profession," as Brown pointed out to the meeting. On the issue of requiring new practitioners to engage only in public practice for several years, it was now suggested that no position be taken in the White Paper, only that the arguments should be set out.

The Ministers were by this point taking the conciliatory position that a confrontation with the profession over salaried general practice would not be advisable:

In spite of our belief that the salaried system is the right one for grouped practice we do not think that a time when the panel system is accepted as the main basis of practice still for the future [sic] is a good time to try to force the conversion of the profession to salaried remuneration. Similarly, we do not feel strongly that, with a centralised panel system, the idea of a part-salary, part-capitation basis is worth pressing against an unwilling profession. (26)

Two other outstanding issues were addressed in accompanying memoranda. The Minister was still in favour of a system of charging patients for their maintenance in hospital, as Beveridge had recommended, while the Secretary of State for Scotland was strongly opposed, disagreeing with Beveridge's distinction between treatment and maintenance as separate aspects of hospital care. Charges, he felt, would deter people from treatment, would be resented, and the hostility to them, especially in Scotland where voluntary hospitals traditionally had made no charges, could not possibly justify the small amount of

revenue to be collected (approximately 8 percent directly from patients). The Minister felt that the abolition of charges would undermine the hospitals' and industrial contributory insurance schemes, which provided some twenty-seven per cent of the voluntary hospitals' income. The Rt. Hon. Ernest Bevin, Minister of Labour and National Service and known for his keen interest in a national health service, noted the industrial friction caused by, and the excessive work and overhead involved in the contributory schemes, and recommended inclusion of all hospital costs in the comprehensive insurance scheme, even if it meant an increase in the contribution. The Committee decided to postpone discussion on hospital charges.

On the second issue, local authority clinic services, both Ministers now recommended they remain with the individual local authorities, rather than being transferred to the proposed joint authorities. (27) This would accord with the preference of the local authorities.

The mid-October meeting of the War Cabinet Reconstruction Priorities Committee changed several fundamental aspects of the earlier planning documents. The Minister now proposed that the main responsibility for the practitioner services should rest with the central department (i.e., the Ministry) rather than with the joint authorities, that existing local authority clinics and public health services remain with the individual authorities, and that unification and co-ordination now be achieved by making the new joint hospital authorities responsible for local co-ordination of the three branches of the service. This they would do by preparing a scheme for co-ordination and submitting it to the Minister for approval or modification, which

would then become binding on all authorities concerned. This major change was approved by the War Cabinet Committee. The Committee requested the Ministers to prepare a draft White Paper, setting out general proposals for the service as a whole. (28)

A New Minister of Health

At its next meeting on the health service, the Committee decided in favour of the position taken by the Secretary of State for Scotland, the Chancellor, Sir John Anderson, and the Minister of Labour against direct charges to patients for hospital maintenance, and instructed the Minister of Health to begin discussions with the voluntary hospitals on alternate methods of funding. (29)

This was the last War Cabinet Committee meeting for Ernest Brown as Minister of Health. In a major cabinet shuffle on 11 November 1943, Mr Brown, who was leader of the Liberal National Party and had been continuously in Ministerial office since 1931, was made Chancellor of the Duchy of Lancaster. Controversy surrounds the interpretation of his change of office, but it is clear from contemporary accounts that he was under severe attack by the medical profession for mooted the possibility of a salaried service, even after they claimed the victory of forcing him to place it "in the discard." In addition, Cabinet records now available indicate that his firm stand in favour of hospital charges was overridden by Cabinet in favour of the Labour position, a free hospital service. Although the precise circumstances of his move are undocumented, these contemporary records would appear to lend support to a broader theory of Cabinet disagreement than that of the opposition of the BMA as the reason for the change of Ministers.

Brown was succeeded as Minister of Health by Mr Henry Willink, a Conservative backbencher and successful barrister, who had been in the House for only three years as the member for North Croydon, and who had been commended for his work, under Ernest Brown, as a special commissioner for rehousing in the London area.

At the same time a new Ministry of Reconstruction, under Lord Woolton, a member of the War Cabinet, was created to deal with all aspects of postwar reconstruction policy. Sir William Jowitt, who had had responsibility, without Cabinet rank, for reconstruction, remained Minister without Portfolio as an aide to Lord Woolton. (30)

The SMA Meet with Clement Attlee

The Socialist Medical Association sent only one other official deputation to the government before the White Paper. They had requested to see Ernest Brown, before the change of Ministers in the autumn of 1943, to discuss progress in his general discussions and the recent Labour Party policy statement. Although their previous contributions were described by a Ministry official as "helpful and constructive," he suggested to the Minister that the time was not right to see the SMA, and that he meet with them after publication of the White Paper.

The SMA arranged instead to send a deputation to the Lord President of the Council, Clement Attlee, 11 November 1943, the day Brown's replacement by Henry Willink was announced. Mr Somerville Hastings referred Attlee to Labour Party health service policy, which the SMA wished to see implemented, "...although it was realised that in a Coalition Government it might not be possible to carry out the Party's policy in its entirety. Certain compromises might, therefore, be

necessary, but his Association was anxious that they should not be of such a nature as to commit the Government irrevocably to an undesirable course of policy." The SMA deputation reiterated several of its and the Labour Party's fundamental policies for a health service including comprehensiveness, universality, free use, full administrative unity, preferably under enlarged local authorities, and abolition of the hospital savings associations.

Attlee was curious about the position of the BMA, and was told by the deputation that the BMA accepted unification but wanted central administration to be by a medical corporation, that they objected to the practitioner service being under the local authorities and that they wished the right to collect fees. "It was pointed out that in the BMA itself there was a difference of view and that only about twenty per cent of the older members were in favour of a completely reactionary policy." There is no indication that Attlee correspondingly briefed the SMA deputation on the nearly finalised decisions on policy for the White Paper, many of which were in accord with SMA and Labour Party policy, taken in the War Cabinet Committee the previous week. (31)

It would appear, in fact, that by the end of 1943 neither the SMA nor the MPU had been given by their Labour colleagues or the Minister a clear idea of precisely what had been won or lost of their proposals in the Cabinet's decisions.

Summary: The Position Prior to the White Paper

Several observations might be made on the state of development of plans for the health service by the end of Ernest Brown's tenure as Minister. It is, first of all, clear that a large body of agreement

existed among the Minister, Liberal National Ernest Brown, the senior Ministry officials who drew up the initial proposals early in 1943, and the socialists and other medical reformers who were the chief proponents of the health service. Indeed the Liberal Party itself had produced a detailed policy document in favour of a free, comprehensive scheme. (32) The agreement centered mainly on reorganising general practice into a salaried, health centre-based service, well integrated with the other branches. It also covered ideas for central and local administration, the Ministry of Health to be the superior, responsible body, with combined or joint local authorities carrying out planning, co-ordination and regional administration.

There was less agreement on unification of the hospital service. The MPU pressed perhaps most strongly and explicitly for nationalisation, with the SMA agreeing in principle but less adamant and possibly likely to have agreed with a compromise scheme of local co-ordination. The Minister at no point agreed with the case for a unified, nationalised hospital system, although in his initial papers and discussions in the War Cabinet Committee he was strongly committed to a co-ordinated hospital service under joint local authority administration.

Despite the BMA's fears, all parties were committed to generous professional representation and remuneration, full professional freedom in practice and free choice of doctor as far as practicable in any locality. The proponents suggested salaried practice in health centres as the most practical way to enhance free choice. The main differences with the BMA concerned issues of control and medical representation at all levels, and remuneration. The BMA held strongly to the view that

not the Ministry but a semi-independent medical corporation should be in charge, and was against any notion that the local authorities be primarily responsible for the daily operation of the practitioner service or of voluntary hospitals. On the issues of coverage for the whole population, rather than ninety per cent, and of Ministerial responsibility for the service as a whole, Brown stood firmly and consistently against the BMA's positions.

He was clearly less convinced by the proponents' arguments that the voluntary hospitals should be financed from rates and the Exchequer, having voiced several times to the Cabinet Committee the argument of the hospitals contributory societies that they would stand to disappear with all-public funding. Similarly Brown was not at any time convinced of the argument for an all-free service, contrary even to Liberal policy; several times, against strong Cabinet opposition he defended Beveridge's case for direct patient fees for hospital "hotel" costs, and deductions from sick benefits for wage-earners in hospital.

Brown's final plan reflected several major changes from his original proposals as a result of representations from the major health services interests -- the BMA, the voluntary hospitals, and the local authorities. His mooted health centre and salaried service proposals had been considerably cut back by the end of his tenure; he had agreed with the BMA on establishing only a limited experiment in health centres, ostensibly as a transitional measure, and on the possibility of payment by capitation and part-private practice. Equally his strongly held preference for administration of a unified service by joint local authorities ultimately gave way under the opposition, for entirely different self-interested reasons, of both the BMA and the local

authorities. He did, however, maintain quite decisively the position, shared with the proponents, that sale and purchase of private practices, in a public service, should end, with adequate compensation.

A.J. Willcocks, in assessing Brown's contribution to building the White Paper, considers that he had little useful role to play following the much publicised confrontations with the BMA in May: "For the rest of 1943, Brown (having discarded his own plan) floundered as he listened to the conflicting views of the pressure groups. His promised White Paper on a proposed plan gradually faded further and further away. At the end of the year, whether because of this failure or not, he gave way at the Ministry to Henry U. Willink." (33)

Recent evidence, however, indicates both the tentative nature of Brown's initial salaried service proposals to the medical profession and the continuity of his overall aims, for example, for unification, comprehensiveness, universality, and the importance of the local authority role, throughout the evolving series of memoranda to the War Cabinet Committee on Reconstruction Priorities during 1943.

It would be more fair to say on the basis of recent evidence from Ministry and Cabinet documents, that the real "Brown plan" was not the one which he was, as it appeared at the time, obliged by the BMA to place "in the discard" in May 1943, but was rather the detailed plan which resulted from the revisions and compromises approved or directed by the Cabinet later in 1943, which formed the substantial foundation of the White Paper already formulated when Henry Willink took over the Ministry in November. The delays in producing a White Paper in 1943 appear to have been due in varying degree to the deliberateness of the discussions with all interested parties, the obvious political

sensitivities and complexities of constructing a national scheme, highlighted by the BMA's readiness to relive the battles of 1912, and, perhaps to the relatively infrequent scheduling of discussions on the health service by the War Cabinet Committee.

Henry Willink, therefore, as the new Minister of Health at the end of 1943, inherited a very complex planning and negotiating situation, but one that was far from a shambles, and a plan that had been modified substantially, but that was far from "in the discard." The state's prerogative to be responsible for and supervise administration of a public health service had been maintained even though there had been apparent compromise on the terms under which the medical profession would practise and the local authorities participate.

Some patterns in the representation of interests were beginning to emerge in the course of the evolution of the Brown plan. While the principles of universality and comprehensiveness were tenets of the proponent groups, they were chosen by the government, it would appear, because of their relevance to the general or national interest. With evident pressure from the Labour Ministers in the Coalition Cabinet, it was determined against Brown's objections and contrary to the interests of the private insurance organisations, that all services would be free of charge and state-funded. These were to be the fundamental bases of coverage and eligibility, of public responsibility and public finance. A state scheme organised on these principles would be medically more effective and politically more acceptable than the alternative, retractive model advanced by the medical profession and the insurance interests.

In addition to these main principles of the advocates, the more

operational goals of serving preventive and positive health, reorganisation of general practice, and close co-ordination of services were accepted, at least verbally. It was at this level of detail, however, that the interests or views of the advocates began to lose ground to those of the medical profession, the voluntary hospitals, and the local authorities. As a result of close preliminary consultation with these three major interests, Brown reversed his original position in favour of salaried, health centre practice, and unification of services under joint local authorities, and made concessions to the terms of participation which the major interests demanded. The views of the advocates on these issues were heard, and even to some extent accepted by the Minister initially, but their rational supporting arguments of medical effectiveness and administrative unification were of insufficient weight against the pressure of the dominant interests.

Even though the state had taken steps to ensure that the overriding public interest would be served through universal access to free services, it appeared, with the Cabinet's acceptance of Brown's concessions, that a conflict of health service models and of goals, with Brown's original scheme, was implicit. In the period following publication of the White Paper, the advocates were to continue to seek representation of their views in planning not only the fundamentals, but the structural details of the service.

CHAPTER 5 -- FOOTNOTES

1. Calder, p. 614.
2. Alan Bullock, *THE LIFE AND TIMES OF ERNEST BEVIN*, VOL. II *MINISTER OF LABOUR 1940-1945* (London: Heinemann, 1967), pp. 194, 217, 240.
3. Calder, pp. 613-617; Bruce, pp. 311-315, describes the "White Paper Chase" that followed Churchill's broadcast, through the next two years, and government action in education, employment, social insurance, and family allowances. See Fraser, pp. 203-206, on the reconstruction activities supervised by Lord Woolton.
4. PRO, Cabinet Papers (hereafter abbreviated CAB) CAB 87/13, P.R.(43)3, "A Comprehensive Medical Service: Memorandum by the Minister of Health and the Secretary of State for Scotland," 2 February 1943.
5. PRO, CAB 87/13, P.R.(43)9, "Draft Interim Report on the Beveridge Plan," 7 February 1943; and P.R.(43)13, "Interim Report on the Beveridge Plan," 11 February 1943.
6. Ross, pp. 83-86; Eckstein, pp. 140-141.
7. PRO, CAB 87/13, P.R.(43)46, "National Health Service," Memorandum by the Minister of Health, 28 July 1943.
8. Eckstein, p. 142.
9. Neville Goodman, *WILSON JAMESON: ARCHITECT OF NATIONAL HEALTH* (London: George Allen and Unwin, 1970), p. 117.
10. *BRITISH MEDICAL JOURNAL*, Vol. IX (29 May 1943): 670; and Vol. I (22 May 1943) Supplement: 61 ff.
11. 390 House of Commons Debates, col. 974.
12. Eckstein, p. 143; see also p. 132.
13. PRO, CAB 87/13, P.R.(43)46, para. 21 (a).
14. PRO, CAB 87/13, P.R.(43)46, para. 23.
15. PRO, CAB 87/13, P.R.(43)46, para. 29(ii).
16. PRO, CAB 87/13, P.R.(43)46, para. 39.
17. PRO, Ministry of Health Papers (hereafter abbreviated MH), MH 77/63, Socialist Medical Association, 26 March 1943, Deputation to Minister, Minutes and Report, and "The Health Centre," SMA Memorandum, May 1943.

18. PRO, MH 77/64, Medical Practitioners' Union, Minutes of MPU Deputation, 14 July 1943; and MPU Memoranda, W. 12, "The Transition to a State Medical Service," August 1942, and W. 13, "Compensation for the Loss of General Practices," April 1943.
19. THE TIMES, 2 June 1943, p. 2, and Leading Article, 3 June 1943, p. 5.
20. See for example the MANCHESTER EVENING NEWS, 3 June 1943, p. 2, which assumed from the tenor of the debate in the Lords that Brown apparently did not intend to introduce a comprehensive service. Several trade union branch resolutions in support of Assumption B were sent to the Minister following the Lords debate.
21. PRO, Cabinet Minutes, War Cabinet Committee on Reconstruction Priorities, CAB 87/12, 16th Meeting, 30 July 1943.
22. Members of the War Cabinet Committee on Reconstruction Priorities in 1943 were: Rt. Hon. Ernest Bevin MP, Minister of Labour and National Service; Rt. Hon. Herbert Morrison MP, Secretary of State for the Home Department; Rt. Hon. Sir Kingsley Wood MP, Chancellor of the Exchequer; Rt. Hon. Viscount Cranborne, Lord Privy Seal; Rt. Hon. Sir William Jowitt KC, MP, Minister without Portfolio. In addition, for discussions of the health service, Rt. Hon. Ernest Brown MP, Minister of Health, and his officials Sir John Maude, Permanent Secretary, and Sir Wilson Jameson, Chief Medical Officer, were generally in attendance.
23. PRO, CAB 87/12, 17th Meeting, 18 August 1943; and 18th Meeting, 8 September 1943.
24. PRO, CAB 87/12, 19th Meeting, 16 September 1943.
25. PRO, CAB 87/13, P.R.(43)55, Memorandum by the Minister of Health on General Practitioner and Clinic Services, 10 September 1943.
26. PRO, CAB 87/13, P.R.(43)72, Memorandum by the Minister of Health and the Secretary of State for Scotland, 9 October 1943.
27. PRO, CAB 87/13, P.R.(43)73, National Health Service, Matters Provisionally Agreed and Outstanding Points, 9 October 1943; and P.R.(43)76, Memorandum by the Secretary of State for Scotland, 12 October 1943.
28. PRO, CAB 87/12, 24th Meeting, 15 October 1943.
29. PRO, CAB 87/12, 29th Meeting, 1 November 1943.
30. THE TIMES, 12 November 1943, pp. 4 and 5. See also Bullock, pp. 284-285, on the creation of the new Ministry of Reconstruction and Ernest Bevin's interest, as a member of the new Cabinet Committee on Reconstruction, in drawing up plans for a health

service.

31. PRO, MH 77/63, Socialist Medical Association, Minutes of SMA Deputation to the Lord President of the Council, 11 November 1943.
32. Willocks, p. 24, discusses the predominant background in local authority public health fields of many senior medical officers in the Ministry. He further suggests that: "Brown's first 'plan' hardly seems to be the brain child of a liberal national, as by political persuasion he was. Indeed the plan bears striking resemblances to plans produced earlier by the National Association of Local Government Officers and the Society of Medical Officers of Health." But Brown's first plan does resemble in several fundamental respects the 1942 draft health policy of the Liberal Party. This proposed the Ministry to be in charge, grouped local authorities, voluntary hospitals co-operating in regional plans, health centres with grouped practice and all auxiliary and diagnostic services as an essential component, all services to be free to all without means test, close co-ordination of health centre and specialist and hospital services, the end of National Health Insurance, basic salary plus capitation as the basis for remuneration of all doctors, GPs and consultants, free choice of doctor, and the continuation of private practice outside health centres only, but the inclusion of a few pay beds in all hospitals. See "Health for the People, Proposals for a Positive and Effective Health Policy for the Nation" (London: Liberal Publications Department, 1942), 80 pp.
33. Willcocks, p. 25.

CHAPTER 6

ADVOCACY AND RESPONSE: THE CHALLENGE

OF THE WHITE PAPER

Final Cabinet Preparations for the White Paper

It is highly unlikely that any of the health service proponents and perhaps only very few Labour MPs were aware in detail of the state of the government's deliberations on the White Paper by the end of 1943. By this time, deliberations were almost entirely internal, the War Cabinet being responsible for the final form of the White Paper proposals and discussion. These of course also had to pass the approval of Prime Minister Churchill, and it is here that the final delay in the issue of the White Paper occurred.

One of the last submissions to the Ministry before the issue of the White Paper was an extensive memorandum by Dr Stephen Taylor (later Lord Taylor), then Head of the Home Intelligence Division of the Ministry of Information, and former assistant editor of the LANCET. Dr Taylor had also been a contributor to Labour Party health policy discussions. His memorandum was forwarded officially to the Minister by Clement Attlee, who identified its author only as a "medical man." It advocated a full-time salaried service; elimination of private practice; the full integration of the voluntary hospitals; more medical schools; a

universal scheme with no class discrimination; remuneration set at a generous level to win the support of the medical profession, with guarantees of professional autonomy; minimal bureaucratic interference; and adequate support staff for general practitioners. A Ministry comment on Dr Taylor's proposals noted that they set out well the views of a group of doctors associated with socialist positions on health in the Labour Party. After an interview with Taylor, it was decided that his position was less "extreme" than indicated in his memorandum, and that he should be engaged by the Ministry of Health in its work following release of the White Paper. (1) This may be taken as perhaps further indication of the consolidation of opinion in favour of a comprehensive state medical service within the Ministry of Health, a consensus including the senior officials and the Minister.

One final pre-White Paper memorandum from the SMA, "Administration of the Health Services," reached the Ministry in early January 1944. The document dealt with details of central and local administration, executive and advisory structures. It advocated statutory advisory groups, with some overlapping among professional, vocational and consumer representation, and a national advisory council with representation from local and regional committees. Perhaps most notably it recommended in favour of a regional, rather than a joint local authority structure, each region incorporating population areas of 500,000 to 2 million. Other innovations were suggested: 1) to improve the scientific aspects of medicine through encouraging research and incorporating a Medical Research Council as an integral part of the health service; 2) to establish Health Workers' Councils to represent nurses and other grades of health workers at levels from local to

national; 3) to have central advisory boards for the medical, dental, and nursing professions and for general health personnel; and 4) to provide for health unit committees, in each hospital or health centre, which would have some decision-making powers. In summary, there would be only two levels of elected authorities, national and regional, while at the local level, all health workers and consumers would be represented. The memorandum was acknowledged with interest by the Minister. (2) Murray makes the point that this memorandum suggested for the first time that doctors and other health workers be given representation on the local and regional committees, and that lay committees, representing the public, should have watch-dog powers. This document became the focal point in early 1944 for discussion meetings held by the SMA throughout the country; in some areas, Wandsworth, for example, SMA branches collaborated with other organisations including trade unions and trades councils to make detailed proposals for the linking of various local health resources. (3)

A request by the Medical Practitioners' Union to the new Minister to send a deputation before publication of the White Paper was turned down, (4) as the government was in its final, and by now relatively independent stages of preparation.

By December 1943 the discussions within the government had reached beyond the War Cabinet Committee on Reconstruction Priorities, which had approved the general issues to be included in the White Paper. The Prime Minister now became involved. Churchill, at that time serving with the Mediterranean Air Command, requested a copy of the paper as soon as it was approved by the War Cabinet.

It took, however, all of January 1944 for the Committee on

Reconstruction Priorities to finalise several outstanding issues. These were: the local authority structure; the organisation of the proposed Health Services Councils, local and central; arrangements for the general practitioner service; and the question of hospital maintenance charges. The Committee's conclusions on these four questions were:

1. The new local authority structure would consist of joint authorities, responsible for direct administration only of the hospital service, and for submitting to the Minister a plan for the coordination of the other services
2. The Health Services Councils were proposed as independent, self-appointed bodies with the right of publishing their views and advice to Parliament and the nation. They would thus be privileged critics of Ministerial power, representing mainly the medical profession and voluntary hospitals
3. Adapting general practice to the needs of a comprehensive service was referred to as the most difficult of the problems faced by the two Ministers. They did, however, remain committed to fundamental change, albeit in stages: "We contemplate a large scale experiment in grouped practice and Health Centres, and these ideas are placed in the forefront of the scheme. But only experience can show how far and how fast a change-over to the grouped system should be made." It had now been determined that in Scotland the central government should be responsible for health centres, while in England it was proposed to have practitioners contract jointly with the local authority and the Central Medical Board.

A universally salaried service was rejected, salaries being proposed only "where necessary to efficiency," for example in health centres, and optional for the doctor to choose in other circumstances.

Private practice would be limited to a certain proportion of the total of a doctor's practice, and prohibited for the first few years of a new doctor's service.

Sale and purchase of medical practices was termed: "highly undesirable...", and it is regrettable to miss a chance to be rid of it." The cost of compensating doctors in existing, purchased practices was estimated at forty million pounds

4. The question of maintenance charges for patients in hospital had not yet been resolved. For Scotland it was rejected outright by the Scottish local authorities and voluntary hospitals (where it was the custom not to charge patients) and by the Labour Secretary of State for Scotland, Tom Johnston. For England, however, both Brown and Willink held to the view of the English voluntary hospitals, that charges were a fundamental part of the provision of care in voluntary hospitals, and vital for the

continued existence of the contributory schemes, a form of voluntary hospital insurance. This view had been reinforced in a discussion between the Ministers of Health and Reconstruction, and Sir William Goodenough (Chairman of the Nuffield Provincial Hospitals Trust), Sir E. Pooley (Honorary Secretary of King Edward's Hospital Fund for London), and Sir Bernard Docker (Chairman of the British Hospitals Association), who were united in their opposition to dropping hospital charges, which they felt would "gravely jeopardise the whole voluntary movement." Indeed the hospitals representatives wished to see voluntary contributory schemes extended in coverage. Thus the Minister of Health stood by his view, recommending a one pound per week charge with a means test and subsidies for those unable to afford it. The Ministers jointly could only recommend that the War Cabinet choose between charges or no charges, and implement a system uniform in England and Scotland. (5)

By the end of January, final decisions had been made by the War Cabinet Reconstruction Committee. The proposed hospital maintenance charges, still supported by all major voluntary hospitals interests, by Minister Brown and subsequently by Willink, were dropped entirely in early January under pressure from the Labour members, particularly Thomas Johnston. Minor changes were made in the local and central Health Services Councils, and to facilitate professional representation on local health authorities; alterations were made to the health centre proposals, particularly to make individual county and county borough councils responsible in England and Wales, and to provide for a three party contract for doctors. With respect to sale and purchase, the White Paper would contain no specific proposals, but would suggest full discussion with the profession. (6)

This was the stage, before consideration by the full War Cabinet, at which Lord Woolton, Minister of Reconstruction, commended the draft White Paper to the Prime Minister, with an explanation of the evolution of the proposals.

Lord Cherwell, Paymaster General, also commended the draft White Paper to Churchill in a letter, noting that it "represents a courageous

attempt to find a via media between the conflicting views and interests," and he expressed the hope that it would be accepted by the Cabinet. He anticipated opposition from the medical profession concerning inadequate representation in the administrative bodies, payment of salaries in health centres, and coverage of the whole population without means test. Supporting the principle of universality, Lord Cherwell considered it "intolerable" to limit access to a publicly funded scheme only to poorer groups. He expected complaints also from local authorities and voluntary hospitals about loss of autonomy to the larger public authorities, but reiterated his belief in the basic plan. (7)

The War Cabinet met 9 February 1944, Chaired by the Prime Minister, to discuss the draft White Paper. It was introduced by Lord Woolton, who asked for approval to publish it as a discussion document. It had the unanimous approval of the Reconstruction Priorities Committee, after many months of preparation and the reconciling of many divergent opinions. Lord Woolton reassured the Cabinet that:

1. The abolition of private practice was not involved, nor would any class of persons be denied treatment in the public health service, merely by virtue of ability to pay privately
2. Any comprehensive service would pose some threat to private practice, but proposals for grouped practice in health centres or elsewhere would increase the efficiency of the rank and file of the profession
3. There would be no large bureaucratic machine directing doctors, as had been suggested by some; the state would act in an obligation to provide a universal service, but its powers of direction were not drastic and would not interfere with professional freedom
4. The whole basis of the medical profession would not, as had also been suggested, be undermined. The thirty year success of the Scottish Highlands and Islands medical service indicated increased medical efficiency along with the retention of private

practice

5. All references to Sir William Beveridge in the introductions to the White Paper and official summary were to be removed.

With these reassurances the War Cabinet approved the publication, for 17 February, of the Paper as a discussion document only, representing no final position of the government (at Churchill's request), and planned the first Commons debate for two to three weeks later. Labour Cabinet Ministers Clement Attlee, Ernest Bevin, and Herbert Morrison were present, in addition to Thomas Johnston, Labour Secretary of State for Scotland, and, of course, the Conservative Minister of Health Henry Willink. (8)

The following day, 10 February, Churchill, indicating the decision to publish the White Paper was too precipitate, especially considering the potential problems in launching such a scheme, ordered a delay in publication, pending special meetings of the War Cabinet and the full Cabinet. In a candid comment on the extreme pressures of wartime politics, Churchill wrote to Foreign Secretary Anthony Eden: "It is absolutely impossible for me even to read these papers let alone pass such a vast scheme of social change through my mind under present conditions. ... I do not want the Government to get into trouble which may tend to break up the Coalition in this critical year." (9)

Lord Woolton replied to Churchill's request for a delay, commending the White Paper again as timely considering the government's commitment to a health service, and as an ideal scheme from a party political standpoint:

If you are to have a national service, I am satisfied that you will not get one which is more acceptable to the Conservative point of view, and more economical of public money than the scheme which has been thrashed out

by the Reconstruction Committee. ... This is a compromise scheme but it is a compromise which is very much more favourable to the Conservative than to the Labour Ministers; and, when it is published, I should expect more criticism from the Left than from Conservative circles. My difficulty on the Committee has been to persuade the Labour Ministers to accept a scheme which fell so far short of their desire for a State salaried service; and I had great trouble in persuading the Labour Ministers at the last moment to refrain from criticising the scheme at the War Cabinet on that ground.

If discussion of the whole scheme is to be reopened, particularly if it is known, or believed, that this is being done to meet the views of Conservative Ministers, I fear that the Labour Ministers might withdraw their support of the scheme and stand out for something more drastic which would be far more repugnant to Conservative thinking. (10)

Lord Woolton also wrote the same day to Foreign Secretary Anthony Eden, explaining in greater detail the nature of the political compromise in the War Cabinet Reconstruction Committee over particulars of the health service proposals. He noted the difficulty he had had to secure the support of the Labour Ministers, especially the Deputy Prime Minister and Mr Morrison. The split in Conservative ranks was small by comparison, but if opened, could destroy their own political advantage:

The Labour Party found it very difficult to swallow the idea that in the Health Centres that are to be set up doctors who are not completely whole-time salaried servants of the State should be allowed to practise.

I mention this to show you that I have gone to much trouble, as chairman of the Reconstruction Committee, to get the Labour Party to the "middle of the road." If the Conservatives turn down the compromise at which we have so laboriously arrived on this issue, there will be little hope of getting the socialists to arrive at a compromise on the other issues with which the Reconstruction Committee is faced, and on which they have been publicly expressing their convictions for many years.

Woolton noted that Eden had been asked to speak with Conservative members of the Reconstruction Committee, and requested that he convey

the foregoing explanation to any dissenters from the White Paper positions before reporting to himself and the Prime Minister. (11)

The War Cabinet met again 11 and 15 February to continue discussion of the implications of the White Paper. After full reassurances from the Ministers that the scheme would have no major deleterious effects on voluntary hospitals or private practice, but would rather put the hospitals on a sound financial basis and greatly improve the quality and distribution of general and specialist practice, the War Cabinet reaffirmed its decision of 9 February to publish the White Paper as a basis for discussion and negotiation. (12) The Paper was duly published in mid February and debated in the House of Commons a month later. (13)

Responses to the White Paper

In general, reaction to the White Paper was favourable. THE TIMES considered the proposals to be: "an eminently sensible compromise. The various parties in the Government have subordinated party views to the production of an agreed plan rather different from what would have been produced by any party government." The same day's leading article gave unreserved praise to the scheme, particularly to the goal of making the best services available to all without charge. It approved the joint authorities as a necessary expedient pending local government reform, and approved removing the competitive element from grouped general practice, noting doctors "must therefore work as a salaried team or receive some other form of remuneration equivalent to a salary." Dr Guy Dain was quoted as saying the BMA was entirely in accord with the objects and general principles of the scheme, and would be sending a questionnaire to all doctors to ascertain their views. (14) The health

service proponents, since they were in substantial agreement with at least the fundamental proposals, were left in the position of being obliged to defend the White Paper and at the same time to advance their own notions of either a 'socialist' health service, or, as the TUC advocated, one geared more to issues such as preventive health, health workers' rights and democratic control, industrial medicine, and full extension of dental and optical care.

Socialist Medical Association Reactions

On behalf of the SMA, MEDICINE TODAY AND TOMORROW gave the "warmest welcome" to the White Paper's intention "to divorce the care of health from questions of personal means or other factors irrelevant to it; to provide the service free of charge and to encourage a new attitude to health ... the promotion of good health rather than only the treatment of bad." It was noted that the basic principles on which the plan was modelled, especially elimination of insurance and reorganising general practice, were sound; indeed much was "clearly drawn from material that first appeared in these pages [i.e. MTT]." But the language of the White Paper was seen as that of compromise, meaning that all interested in a socialist solution should keep up pressure on the Government. Several shortcomings were identified and remedies prescribed:

1. The service should be unified; the variety of responsible authorities proposed were not sufficiently linked with each other
2. "The greatest weakness . . . is, without doubt, the attempt to maintain private practice within the national service." All health service practitioners should be full-time, and any private practice should be outside the service. "To permit a doctor who is under [public] contract to accept private fees for the same service as he has agreed to give without fee is to

introduce into public life in this country methods which in other places would be called graft, racketeering, or black market." The analogy was drawn with private payments to the police or fire brigade for extra service

3. The abolition of sale and purchase of practices, not at all difficult as the White Paper implies, should be effected immediately
4. Salaried public practice in health centres should be made attractive enough, through generous remuneration, to engage at least sixty per cent of existing practitioners.

MEDICINE TODAY AND TOMORROW concluded that the compromises in the scheme did "not arise from any doubt in the minds of the Government as to the correct method of running this service; they arise from a fear the profession may resist." (15)

The SMA dedicated the remainder of 1944 to campaigning for its own, and the Labour Party's, priorities, chiefly for a salaried health service. A resolution passed by the SMA Annual General Meeting, and sent to the Minister, echoed views already voiced by the TUC, Labour Party and several unions. It accepted the concessions to private practice and the voluntary hospitals as necessary, but felt the public service could be made so efficient and attractive as to eclipse the private alternatives. This success would depend "mainly on the widespread establishment of health centres of the highest possible standard," which could best be assured by public pressure on all levels of government concerned, in which effort the SMA would seek to enlist as many health workers as possible. The statement concluded in the same spirit of militant enthusiasm typical of much of the SMA's activities: "We urge all working class and progressive organisations and individuals to make this matter their close concern. The people's interest in their own welfare is the real key to a better future." (16)

The SMA took note of the BMA Questionary to its members regarding

the White Paper, the results of which indicated a good deal of support, especially among younger and armed forces doctors, for many of the White Paper proposals including health centres, salaries, abolition of sale and purchase, and a one hundred percent, free and comprehensive service. (17) Although the BMA arrived at an opposite interpretation of the Questionary results, the SMA was greatly encouraged at the support for various of its own fundamental policies. (The antipathy of most doctors to working for local authorities was noted, although assumed to be an objection that could be dealt with to the satisfaction of the profession in the structuring of the scheme.) Thus the SMA launched a full publicity and education campaign, issuing three pamphlets during 1944, explaining and defending the White Paper, advocating the SMA programme, and answering in detail the BMA and BHA which, from March 1944, were very much on the attack against certain of the proposals. (18) The third SMA pamphlet was issued after Willink had made it known in October that a number of new agreements had been reached with the BMA and BHA and the local authorities, following the extensive negotiations of the summer and autumn.

Reaction of the TUC and Health Workers' Organisations

The TUC embarked on a year-long consideration of the White Paper in March 1944. The first document to be approved by the General Council, prepared by a joint subcommittee of the TUC, Labour Party and Co-operative Congress, welcomed the White Paper as a large step forward, but regretted the many gaps and certain of the orientations of the proposals. In particular the position paper regretted the hospital system would not be unified and that a salaried practitioner service was

not proposed. It was recognised that the co-operation of the medical profession was necessary; to that end all conditions of practice in the public service should be such as to attract the best doctors. Other suggestions were for a first-class rehabilitation service; official representation of non-professional health workers; a commitment to expand medical research and co-ordinate it with the preventive and curative services; and finally, it was strongly suggested that an industrial health service should be interwoven with the national service as a whole, with the closest local contact between industrial and personal or family medical care personnel. Omissions noted from the scope of the White Paper were nutrition, environmental health, housing, and health education, policies on all of which would be relevant to the mandate of a comprehensive service to improve the nation's health. (19)

The General Council of the TUC decided in March to make an overture to the BMA for joint discussion of the White Paper, and also began detailed consideration of a document submitted by the Association of Scientific Workers, which was to form the basis for the TUC policy paper on an industrial health service submitted to the Minister in December 1944. (20)

In May began a brief series of discussions with the BMA, through a standing joint committee which had not met since 1939. The discussions covered the entire range of the government's proposals, and the two organisations' views. Both bodies agreed that the hospital system should be organised in regions, with boundaries not necessarily co-terminus with local authority boundaries, a position which was to gain increasing favour as the joint authority idea lost ground, and which was to form the basis of the hospital service under the 1946 Act.

In these discussions the TUC declined to press its own policy of unification of the two hospital systems, but rejected any further concessions to the voluntary hospitals than those in the White Paper. The BMA wished a full operating subsidy to be paid to voluntary hospitals, rather than the nearly-full subsidy which, the White Paper argued, would leave some room for voluntary initiative in fund-raising. The TUC representative did argue for salaried general practice, against BMA opposition that professional independence and an ideal doctor-patient relationship could only be secured with remuneration according to number of patients. The BMA claimed not to be opposed to health centres in principle, but rather to salaried practice, and wished "controlled experiments organised on a scientific basis" to determine the most appropriate type of facilities and remuneration. In contrast, the TUC saw no reason to delay, and wished local authorities to be encouraged to begin building and experimenting in health centres. On the important additional matter of an industrial medical service, the TUC had already submitted a memorandum to the Royal College of Physicians, and agreed to communicate further with the BMA on the assumption that substantial agreement existed. The organisations did not reach formal conclusions, but acknowledged each other's valuable contributions. (21)

The Women Public Health Officers' Association, representing mainly local authority health workers, in March published and submitted to the Minister its comments on the proposed scheme. Health centres were especially praised; they would be the focal point of all local medical care, preventive and curative, and of child and maternity clinic and home services such as midwifery and health visitors.

Shortly thereafter, resolutions were submitted from a national

conference of the Social Security League (closely connected with Beveridge) and the Health Workers' Council (which had strong SMA representation). Again, teamwork and health centres and attractive conditions of work for all health workers were stressed, in addition to the inclusion of an industrial health service. The joint conference prepared for a national campaign to urge implementation of the White Paper with the additional proposals. (22)

Many trades councils and trade union branches, along with many community groups, women's co-operative societies and others, petitioned the Minister during 1944 for full implementation of the White Paper. These numbered, among others, several dozen trade union branches from Yorkshire, many of them representing the Yorkshire Miners' Association; the Leicester and District Trades Council; the Coatbridge Trades Council; the Medway Trades Council; and the London Women's Parliament. All supported health centres; the trade unions especially called for inclusion of an industrial medical service. (23)

The Medical Practitioners' Union was one of the health workers' organisations able to see the Minister in the summer of 1944. In advance of their deputation the MPU forwarded a memorandum, in general agreeing with White Paper proposals, but stressing salary as the normal method of payment for full-time practitioners (but with optional payment by capitation), and the "utmost importance" of health centres, which should be built early on a wide scale. Positions were taken in favour of strong medical representation, the operation and ownership of health centres and hiring of all doctors by the Central Medical Board, in addition to a number of minor suggestions. In an oblique reference to the BMA and the SMA, the MPU described itself as representing "the more

progressive of general practitioners, not those whose instincts make them increasingly wary of all new plans, nor yet those who are prepared to go to any length in support of academic political theories."

The Minister was briefed by his officials, in advance of the deputation, on the status of the MPU, and was advised to avoid suggesting the MPU might take part in formal negotiations. It would not be among organisations chosen by the BMA as representative, "since the MPU and the BMA are at loggerheads, the MPU being a much smaller rival body with left-wing tendencies." Willink was advised of the MPU's position in close agreement with the White Paper, and of the several useful suggestions the memorandum made, especially concerning adequate medical representation, and the appropriate employing authority for doctors. It appeared unlikely, the Minister was advised, that the MPU would press some of its stronger views of 1942. The meeting with the Minister, therefore, was a rather perfunctory exchange of general agreement, the MPU claiming greater support for the White Paper than any other professional organisation, and emphasising a scheme in which the medical profession would be happy to work. (24)

Another of the TUC affiliates, the Hospital and Welfare Services Union (earlier the National Union of County Officers), made direct representations to the Minister. The Union, however, was more critical and less conciliatory than the MPU about the White Paper, and, in addition, was extremely critical of both the TUC and the Ministry for, in their view, not representing adequately the interests of health services workers. The Union's memorandum referred to the White Paper scheme as not a health service but a treatment service, and attacked the Minister for his failure to consult organised trade unionists "in any

degree" in its preparation: "Those who have been consulted do not represent the mass of health workers," the Union claimed, and charged that the TUC had itself failed to consult the entire range of health workers' organisations. The document called for "one closely knit Trade organisation" in the health service, along with official joint consultative machinery and the right of direct trade union representation. The White Paper, it noted, was weak in preventive health policy, especially in the environmental and industrial health areas. The Union was also critical of compromises with respect to private practice and the apparent lack of acceptance of the principle of uniformity of treatment (i.e., in one high-quality public service) along with universality. On the hospital service proposals, the Union called for trade union opposition to voluntary hospitals through withdrawal from contributory insurance schemes, and for their takeover by the state or by local government.

The Ministry, in keeping with its policy of attempting to centralise negotiations through the major interested bodies, in July approached the Ministry of Labour and the TUC, and secured agreement that the TUC should be the only association representing health workers to send a deputation, although it might include member unions in its group. It was noted that this would place in a difficult position the National Association of Local Government Officers (NALGO) which was not a member of the TUC. The Hospital and Welfare Services Union, informed of this policy, redirected its efforts later in 1944 through the TUC, submitting material on health workers' representation and an industrial health service for the 1944 Congress of the TUC, by this time voicing support for full implementation of the White Paper as a minimal step

toward a preventive health service, and stressing the rights of health workers and patients. (25)

In April, the London Trades Council wrote to all London MPs and to the Minister with a resolution urging implementation of the health service and noting opposition to combined private and public practice, to sale and purchase, and to the continuation of the voluntary hospitals. The London Labour Party's conference in May welcomed the White Paper as a minimum programme, also urging the end of sale and purchase and of private practice in the public system, and a more thorough unification of all the branches of the service. Other resolutions making the same general points came from the Newcastle and District Trades Council, the Hackney Old Age Pensioners' Association, and the Association of Scientific Workers, which also submitted a memorandum on an industrial medical service. (26)

Labour Party's Response

The Labour Party's first major consideration of the White Paper was in the form of a Public Health Advisory Committee memorandum drafted by Dr Stephen Taylor in June 1944. The lengthy document began by noting the difficult battle ahead against powerful vested interests, and urging the Labour Party and the trade unions to publicise the plan, and Labour's modifications, and to rally public opinion to disarm the scheme's opponents and to assure a popular base of support for going beyond the White Paper proposals.

While the Labour Party believed in the principle of a salaried, unified service, Taylor suggested, it should be prepared to accept the White Paper compromise on the assumption that a successful health

service, based on centrally funded health centres, administered by joint authorities, would soon supersede private practice. Generous terms should be given to medical staff, and sale and purchase of practices abolished, with compensation. Taylor also supported the strong central and local medical representation in the proposed Health Services Councils, providing the democratic control of the executive side of the service were not weakened. He emphasised that the "false social distinction" among grades of staff and patients should be eliminated in the health centre arrangement, as a new departure in the social relations of medical care provision, and he outlined a democratic structure of interlocking staff committees.

With respect to industrial medicine, Taylor noted there were strong reasons for linking it with the Ministry of Labour, although it should at least be a fully public service, co-ordinated with general medical provisions. Improved medical research, education, and health promotion should also be part of the national scheme. (27)

The voice of the Labour Left, TRIBUNE, gave qualified approval to the White Paper. It accorded well with Labour's insistence on a publicly operated comprehensive service, free at time of use, with no means test or income limit, meaning, in theory, one class of patient and one class of treatment. The most significant compromises, TRIBUNE felt, were in the area of health centres, where part-private practice and competitive remuneration might be allowed, and in leaving the establishment of the centres to local authority initiative. Another compromise TRIBUNE regretted was the continuation of voluntary hospitals as autonomous units. It approved the joint local authority administrative structure at least as an expedient pending local government reorganisation. "Vigorous

public initiative" was urged in support of an ideal service; Labour controlled local authorities should do their utmost to implement the aims of Labour policy, especially with respect to health centres, which, if successful and popular, should mean the end of private practice. (28)

Joint Labour Party and TUC Initiatives

During the autumn of 1944 the Labour Party and the TUC finalised detailed policy documents on the White Paper. The Minister had by October completed a major round of discussions with the BMA's Negotiating Committee and with the BMA and local government bodies. By mid-October he had announced several significant revisions to the White Paper scheme, including the replacement of the original joint authorities responsible for the hospital service, with a system of hospital regions based on central teaching hospitals. The major interested groups were made aware of these policy changes through October.

By early October the joint committee of the Labour Party, TUC and Co-operative Congress had prepared a collective document which welcomed the original White Paper proposals, but with reservations regarding the co-existence of private and public practice, the retention of a dual hospital system, and the omission of an industrial medical service. Coincident with the Minister's decision to abandon the joint authority concept, the committee also recommended "natural" hospital regions, not necessarily co-terminus with local authorities, although it was assumed that joint authorities would be created to administer the health centres and clinic services. (29) This memorandum was sent to the Minister in early December, as the BMA was holding its annual Conference, and on the

eve of the Labour Party Conference. (30)

The TUC at the same time provided the Minister with its supplementary position paper on the proposed health service, ratified at its 1944 Blackpool Congress. This document made virtually the same substantive points as the joint memorandum, with certain items emphasised by the TUC General Council, including its insistence that research and industrial medicine should be fully integrated in the scheme, and noting the TUC's preference for a single, unified hospital system.

Ministry officials noted in internal memoranda that there was nothing in the TUC's expressed positions that would be likely to cause difficulties for the Minister in proceeding with the White Paper or the various modifications under consideration. It was decided the TUC should be invited to send a deputation representative of member unions in the health services and local government. This deputation was ultimately arranged for March 1945. (31)

By this time, the government was already in the process of discussing, with the BMA and BHA, its second revised draft of alternative proposals arrived at through the difficult round of negotiations beginning in January 1945. Although the TUC was able to make its viewpoint known to the government, through submissions and a very few deputations, its representation in negotiations was clearly not seen by the Ministry to be in the same order of importance as that of the three main "interests" in the service -- the medical profession, the voluntary hospitals, and the local authorities. These interests were continuously consulted, unlike the TUC, which represented the great bulk of hospital and health workers. The TUC, it would appear, was consulted

only after the other three interests, in each round of discussions, and only after the Minister had reached tentative agreement on changes with the major interests.

The Labour Party's 1944 Conference

The Labour Party finished 1944 with its forty-third Annual Conference, 11 to 15 December. The work of the joint Labour Party, TUC, and Co-operative Congress committee on the White Paper was noted in the annual report of the Public Health Committee, which was under the chairmanship of Somerville Hastings of the SMA. The report of the National Executive congratulated the Labour Cabinet Ministers whose influence was to be seen in the three major 1944 White Papers on Social Insurance, Workmen's Compensation, and a National Health Service. Dr D. Stark Murray moved the SMA resolution welcoming the White Paper as an essential part of an overall social security scheme and calling on the labour movement to press for changes to accord with Labour Party policy as articulated in the 1943 statement, "A National Service for Health"; the resolution was carried. (32)

At the Annual Conference, a strengthening of the party's left was evident in the many criticisms of the Labour Ministers in the Coalition. Aneurin Bevan MP, future Minister of Health, attacked the party leader, Clement Attlee, who, he said, "had pitifully failed to represent a Socialist view in the Cabinet." A resolution, moved by Ian Mikardo and supported by Bevan, calling for state ownership of all significant economic sectors, was passed overwhelmingly, despite the Executive's opposition to the Conference taking any position on ownership. Aneurin Bevan was among those elected to the National Executive. He was, at that

time, also among those dedicated to breaking down the depoliticising effects of the Coalition and what was, in his view, the right-wing consensus among trade union leaders, the TUC General Council, and the Labour Ministers. Following the TUC's support in April 1944 for Labour Minister Ernest Bevin's Regulation 1A(A) banning strikes in war industries, which was debated in Parliament in May, Bevan had launched bitter attacks on Bevin and on the TUC leadership for its co-operation with Conservative domestic policy. (33) The TUC had also supported the Labour Ministers and government policy in the 1943 debate on the Beveridge Report, in which Bevan supported the backbench revolt.

Bevan suspected that the TUC leadership were interested not in a left wing victory after the war, but in a continued Coalition, in which they would more readily be able to wield their personal influence. He was, therefore, adamantly opposed to a postwar Coalition, and opposed the position of the TUC leadership sufficiently that he attempted to break their block voting power in the Labour Party by having trade union locals affiliate with Labour Party local branches, with the rationale of providing a more democratic franchise in the party for the trade union rank and file. (34) Bevan's irreconcilable differences with the TUC leadership, and with Ernest Bevin, together with his rising influence in the Labour Party in 1944 and the popularity of anti-Coalition sentiments, were, following his 1945 appointment as Minister of Health and Housing, to make for extremely strained relations with the TUC, and undoubtedly to some extent impeded the bargaining power of the TUC with respect to the health service.

In the interim, however, the role of Bevan and the Labour Left at the 1944 Conference marked the beginnings of organised dissent against

the Coalition. While the Labour Party did not yet wish to dissociate itself from Coalition reconstruction policies, it was becoming clear that Labour was not anxious to allow the Conservatives to make greater compromises in implementing the new social policies, and to reap the substantial electoral credit that would accrue from their enactment.

Trade Union Representations in Early 1945

Early 1945 was the period of consolidation of Conservative health service planning under Health Minister Henry Willink. Some amendments to the White Paper were announced in October 1944, but there was a greater urgency and some sense of finality in bringing the complex negotiations to a pre-legislation point in Willink's discussions of January to April 1945.

The trade unions and the pro-health service forces were equally moved by a sense of urgency to make their views known and influence felt by the government. There had been wide public discussion in the year following the release of the White Paper; there had been much committed agitation for the shared principles of the SMA, Labour Party, and TUC positions on a health service in the two years since the Beveridge Report and the publication of the first detailed Labour movement health service plans. General support had been accorded to the White Paper, as a first step toward the ideal of a fully unified, fully public, state health service.

Knowledge that the government was now concluding discussions with the BMA and the BHA gave rise to apprehension that even the basic principles of the White Paper -- comprehensiveness, universality, and free access -- might be in jeopardy. This was particularly so in light

of the debate at the December BMA conference, which had supported merely the extension of National Health Insurance on a means-tested basis to all but the wealthiest, and elaborate safeguards for private practice.

Many trade unions and major trades councils wrote to the Minister in early 1945, with resolutions noting alarm at the campaigns of the BMA and BHA against fundamental principles of the White Paper. The trades councils included those from London, Sheffield, Burnley, Ayr, Plymouth and district, Hayward's Heath and district, Nottingham and district, Swindon, and Aylesbury and district. Trade unions included the Amalgamated Engineering Union, the National Union of Railwaymen, the Mental Hospital and Institutional Workers' Union, the Clerical and Administrative Workers' Union, the Fire Brigades' Union, the Railway Clerks' Association, the Association of Scientific Workers, the National Federation of Professional Workers, and the National Amalgamated Union of Shop Assistants, Warehousemen and Clerks. Other organisations included the National Guild of Co-operators, the Co-operative Party, the Hospital Almoners' Association, and numerous Labour Party local branches. Virtually all expressed concern at the possibility of concessions to the BMA and BHA, and called for full implementation of the White Paper scheme. (35)

The TUC itself sent a deputation to the Minister in March, having forwarded a policy resolution from its October 1944 Congress urging again that an industrial medical service be incorporated in the new health service. The Minister was advised by his officials to indicate his agreement at least with close co-ordination of industrial and personal medical services, the use of the same doctors in both capacities (as family and factory practitioners) and close central links

between medical staffs in the two branches.

At the meeting, the Minister assured the TUC representatives that the White Paper principle of one hundred per cent coverage was not in jeopardy, despite BMA pressure. He acknowledged that certain major modifications had been arrived at, including the replacement of the joint local authority concept of administration with area planning councils composed equally of voluntary and municipal hospital representatives, to plan, with statutory authority, the hospital service, and advisory bodies for the larger regions, which would be established around university teaching hospitals. It was now felt, in contrast to the White Paper, that a dental service could be included from the start, in accordance with the recommendation of the Teviot Committee.

Mr Tom Johnston, Secretary of State for Scotland, advised the TUC of differences in the Scottish health service, including central government provision and maintenance of health centres, with powers ultimately to delegate the centres to local authorities; it was felt that this way health centres could be built more expeditiously on a wide scale, without awaiting the difficulties and delays of local authority planning.

For the TUC General Council, and on behalf of the MPU (which had three members in the deputation), Mr W.P. Allen, leader of the deputation, sought assurances from the Ministers that there would be no contracting out of the service (i.e., all would pay through rates and taxes, and be eligible for treatment); that such private practice as would be allowed would not be superior in any way to the public service; that preventive health policies should be actively pursued; and he urged

that medical education be made free, with equal opportunity to all. Other items of TUC policy were stressed: fair remuneration for doctors and all health workers; a rehabilitation service integrated into the general scheme; the importance of adequate nursing staff and the provision of all ancillary services including ambulances; and the incorporation of industrial medical services with the elimination of private employers' "works doctors." The TUC and its member unions were not in favour of retaining independent voluntary hospitals, even on the basis suggested in the White Paper, but took note of the government's reasoning. They wished assurances that the hospital proposals would not be weakened in any way.

The Minister, on the question of private practice, said the government was reluctant to create by compulsion two exclusive alternatives, obliging doctors to choose one or the other, and risking the possibility of a majority remaining out of the public service. There would be limits to the size of a part-private practice to protect the public patients. "The aim right through was to create a service far better than had ever existed before." Preventive services could very easily be incorporated in the health centres. Terms and conditions in the public service would be such as to attract and retain good doctors. With respect to rehabilitation, there was room for improvement based on war experience, and for integration with the curative services. The Minister felt the TUC's position on voluntary hospitals was "helpful and reasonable" but thought the government's course was correct; the proposed area planning machinery should encourage only healthy competition among voluntary and municipal institutions. The Minister promised that the nursing profession would be represented on planning

and advisory committees. In the area of medical education, recommendations of the Goodenough Report would be followed and student grants considered.

With respect to industrial health, the Minister noted the similarity between the TUC's and BMA's positions; both regretted the division between industrial and personal health. The government noted the need of the Ministry of Labour for medical services in industry, but "any attempt to obtain complete integration with the general service at this stage might endanger the progress of the health service proposals as a whole"; it would take some time to prepare the complex legal changes, and it was more important, given the urgency, to relate the health service to the rest of the social insurance scheme about to be implemented. Mr Johnston noted his appreciation of the TUC's position on industrial medicine, and its dissatisfaction with meagre factory medical services provided by employers, often in their own direct interest, but reiterated the Minister's point that a full industrial scheme could more easily be provided later, after the complex arrangements of the general service had been accomplished.

The Minister noted that discussions with the BMA and BHA were not yet complete. The government was likely, however, to drop the proposed requirement that doctors new to the service engage in full-time public practice for some years; it would alter arrangements for directing doctors to underdoctored areas; and alter the health centre remuneration method to basic salary plus capitation fees. It was essential, he said, that health centre doctors not be in competition but in partnership. Sale and purchase was a matter still under consideration. The Minister promised only to consider the matter of recognition of trade unions in

voluntary hospitals, one of the TUC's major points. (36)

The TUC Joint Social Insurance Committee and the General Council discussed the positions taken by the Minister until June, when a further draft policy memorandum was prepared. This stressed that there should be no withdrawal from the White Paper and noted the irony, considering the medical profession's interest in freedom, that there should be not even the option for a doctor to choose remuneration by full salary. This memorandum had to await the change of government to be sent to the new Minister in August, and was not discussed with Mr Bevan until he received the TUC's first deputation on the health service in November 1945. (37)

The General Council also had discussions with voluntary hospital representatives, initiated by the BHA in late 1944 in order to exchange views without commitments. Sir Bernard Docker, President of the BHA, stressed representation of voluntary hospitals on planning committees and the need for co-operation with municipal hospitals. He admitted it should be possible for hospital staffs to join unions and regretted the neglect of industrial medicine on the programmes of teaching hospitals. The TUC, having put the case on behalf of the Amalgamated Engineering Union for a unified hospital system, and having commented on the irony of workers paying compulsory contributions to "voluntary" hospital insurance schemes, decided there should be no change of TUC policy with respect to the hospitals. The discussion was carried on in more detail in August 1945, before Bevan's announcement of hospital policy. At this meeting the BHA agreed to support the right of staffs, including nurses (who, the TUC claimed, were often discouraged by senior nurses and the Royal College of Nursing), to join without duress any trade union. The

BHA at this time again rejected a unified hospital system, but favoured full co-operation, and perhaps the rotation of medical and nursing staffs between voluntary and municipal institutions in order to break down the traditional barriers. (38)

The Health Workers' Council

Following the TUC's deputation in March, the Health Workers' Council, which was formed in 1943 to represent approximately twenty unions and professional associations in the health services, (39) sent a deputation to senior Ministry officials. The Council was founded upon an extensive list of principles: promoting a comprehensive, unified health service; the pooling of all medical knowledge and resources for the community; education of the public in preventive health and the best use of treatment services; adequate remuneration and working conditions for all health workers; democratic teamwork among doctors and other health workers as the "basis and the inspiration of the Service"; full representation of all health workers on planning bodies, with "a large measure of control by elected committees of all health workers, who should have collective and individual right of access to the regional authority"; and, the promotion of adequate nutritional standards, health education, leisure and recreation, and "optimum industrial, social, and environmental conditions."

The Council registered its opposition to the BMA proposal to extend the insurance panel system, its acceptance in general of the White Paper, and its view that the health service would be successful only with the confidence of health workers. This, it said, could be achieved by the rights of organisation and representation, teamwork, and adequate

pay and working conditions. It also made similar points regarding the integration of a full industrial health service, and, as the TUC had done, emphasised health centres, prevention, and a national ambulance service.

Ministry officials heard the deputation largely without comment, except to note that it had been decided to leave industrial medicine on the side "for the moment to avoid imperiling the remainder of the scheme." (40)

The Labour Party's 1945 Conference: the End of the Coalition

By late May, when the Labour Party held its 1945 Conference at Blackpool, it was clear that the Coalition was not destined to last much longer. Attlee and Bevin had agreed with Churchill to maintain the Coalition until the end of the war with Japan, Germany having conceded on 8 May. Neither the National Executive Committee nor the Conference would accept this condition for remaining in the government. The leadership then united in favour of ending the Coalition, a position Aneurin Bevan had taken for some time.

At the Conference, 21 to 25 May, a number of local Labour branches submitted resolutions urging resistance to the BMA's moves to compromise the White Paper. The SMA proposed a major resolution on the health service regretting the Minister's alterations as violating the principle of democratic control of major services (such as the hospitals) by elected authorities, inherent in the new proposals for hospital regions and for greater representation for voluntary hospitals. The resolution reiterated the health policies of the SMA and Labour Party, and called for nothing less than implementation of the White Paper scheme. Dr D.

Stark Murray attacked the Minister's proposed modifications as: "a perfect example of Toryism at work. ... The Labour Members of the Cabinet had forced through the acceptance of the principles on which we stand, and [it was obvious that] the Tory Party dare not oppose this publicly and openly. But they set up a scheme whereby they could destroy the White Paper without even coming into the open." Willink's revisions, circulated confidentially to the BMA, Murray charged, were for "a scheme which would completely destroy all hope of a National Health Service as we have envisioned it in the past." Dr Edith Summerskill MP, speaking for the National Executive, assured Dr Murray of support in opposition to Willink's modifications. She suggested that a salaried system would augment doctors' freedoms and that the dual hospital system should end. There should be equal opportunity for women in medical education, and democratic representation of all health workers, not medical domination of health service administrative committees.

The SMA resolution was carried, and became the health policy section of the Labour Party's 1945 Election manifesto, "Let Us Face the Future." (41)

The Caretaker Government

Attlee delivered notice to Churchill during the Labour Conference of the party's decision to quit the Coalition in October. Prime Minister Churchill, having rejected an October election favoured by Labour and the Liberals, tendered his resignation 23 May, and was asked by the King to form a caretaker government until the dissolution of Parliament 15 June, and the election 5 July, with the counting of votes delayed until

25 July due to war conditions. (42)

This left health service planning somewhat suspended. As we shall see in the next chapter, however, the Caretaker government did reformulate the Coalition's modifications of the White Paper, making significant amendments. These were intended to be published in a new 1945 White Paper which was, in the end, not released before the 5 July election. Hence the Caretaker government's changes remained shrouded in secrecy.

The health service proponents had put their case to the government and although at no point did they have the official status in negotiations accorded by Mr Willink to the BMA and BHA, it was clear, particularly from the compromises that were inherited by the Caretaker government, that the Labour Ministers of the Coalition did have some significant influence in the framing and retaining of many of the White Paper proposals prior to the 1945 election. Labour's resolve to carry through its own party policy, as a government, was, of course, another matter. "The Labour Party," says D. Stark Murray of the 1945 Conference, "by adopting the [health service] resolution had thus cleared away any misconception that it was bound by the compromises Willink had negotiated with the medical profession. ..." (43) The realities, however, were somewhat more complex, as the planning record of Aneurin Bevan, Labour Health Minister after the July election, was to demonstrate.

CHAPTER 6 -- FOOTNOTES

1. PRO, MH 77/42, General Representations, Memorandum forwarded by C. R. Attlee, 11 December 1943, and related notes.
2. PRO, MH 77/63, Socialist Medical Association, Memorandum, 13 January 1944, and Minister's reply, 18 January 1944.
3. Murray, pp. 64-66.
4. PRO, MH 77/64, Medical Practitioners' Union, letter to Minister, 1 February 1944.
5. PRO, Prime Minister's Papers, PREM 4-36/3, National Health Service, War Cabinet Reconstruction Committee Memorandum R.(44)2, 3 January 1944.
6. PRO, PREM 4-36/3, War Cabinet Reconstruction Committee, R.(44)24, 31 January 1944, Notes by the Minister of Reconstruction.
7. PRO, PREM 4-36/3, 8 February 1944, letter of Lord Cherwell to Prime Minister Churchill.
8. PRO, War Cabinet Conclusions, CAB 65/41, W.M. (44) 17th conclusions, minute 2, Meeting of War Cabinet 9 February 1944.
9. PRO, PREM 4-36/3, Memorandum M.95/4, from Prime Minister Churchill to Foreign Secretary Anthony Eden.
10. PRO, Cabinet Papers, CAB 124/244, Minister of Reconstruction, Draft White Paper, NHS, Correspondence: Memorandum from Lord Woolton to Prime Minister Churchill, 10 February 1944.
11. PRO, CAB 124/244, Memorandum from Lord Woolton to Foreign Secretary Anthony Eden, 10 February 1944.
12. PRO, War Cabinet Conclusions, CAB 65/41, W.M. (44) 21st conclusions, minute 2, Meeting of War Cabinet 15 February 1944.
13. A NATIONAL HEALTH SERVICE, Cmd. 6502 ["White Paper"] (London: HMSO, February 1944). The White Paper itself is discussed by Lindsey, pp. 33-36; Eckstein, pp. 143-144; Calder, p. 623; Ross, pp. 86-87; Bruce, p. 316.
14. THE TIMES, 18 February 1944, pp. 4,5,8.
15. MEDICINE TODAY AND TOMORROW, 4, No. 5 (March Quarter 1944); Murray, pp. 66-67, discusses the SMA reaction.
16. PRO, MH 77/63, Resolution submitted by SMA, 21 June 1944.

17. The BMA questionnaire is discussed in Eckstein, pp. 147-149; Lindsey, p. 38; Ross, pp. 88-89; Calder, p. 624; and Forsyth, pp. 17-18.
18. Murray, p. 68.
19. TUC, Joint Social Insurance Committee Memorandum 5/1, 9 March 1944.
20. TUC, Joint Social Insurance Committee Minutes, 1944.
21. TUC, Joint Social Insurance Committee, Summary of Discussions with the British Medical Association on the National Health Service White Paper, 30 August 1944.
22. PRO, MH 77/42, General Representations: submissions from Women Public Health Officers' Association 3 March 1944, and the Social Security League 12 March 1944.
23. PRO, MH 77/43, Representations, August-December 1944.
24. PRO, MH 77/64, Medical Practitioners' Union Memorandum W.106, "White Paper and Family Doctor," June 1944, and Ministry Memoranda of MPU deputation 24 July 1944.
25. PRO, MH 77/73, N.H.S. Representations, TUC: Memorandum from Hospital and Welfare Services Union, 6 July 1944, and associated correspondence.
26. PRO, MH 77/42, April-July 1944.
27. Labour Party, Public Health Advisory Committee, Memoranda R.D.R. 268, June 1944, and R.D.R. 272, September 1944.
28. TRIBUNE, No. 374, 25 February 1944.
29. TUC, Joint Social Insurance Committee, Joint Sub-Committee of the TUC, Labour Party, and Co-operative Congress, "Memorandum on the Government White Paper, A National Health Service," 30 October 1944. See also Labour Party, Policy Committee, "Draft Statement on the Government White Paper on a National Health Service," R.D.R. 277, November 1944.
30. PRO, MH77/43, Memorandum from the TUC, Labour Party and Co-operative Congress, 8 December 1944.
31. PRO, MH77/73, TUC General Council, Supplementary Report on the Government White Paper on a National Health Service, with correspondence from Sir Walter Citrine, General Secretary, to H.U. Willink, 8 December 1944, and related Ministry memoranda.
32. Labour Party, ANNUAL REPORT, 1944.
33. DAILY HERALD, 22 May 1944.

34. Michael Foot, ANEURIN BEVAN: A BIOGRAPHY, Volume I, 1897-1945 (London: Mac Gibbon and Key, 1962), pp. 414-15.
35. PRO, MH77/43, Representations, January-May 1945.
36. PRO, MH 77/73, TUC Deputation to the Minister of Health, 8 March 1945, Official Report and related memoranda.
37. TUC, Joint Social Insurance Committee, Memorandum 9/2, Deputation to Minister of Health 8 March 1945; and minutes of meetings 12 April, 15 April, 15 May, 13 June, and 3 July 1945.
38. TUC, Joint Social Insurance Committee, Minutes, Meetings with British Hospitals Association, 10 January 1945, and 2 August 1945.
39. Member organisations of the Health Workers' Council included: the Associations of Occupational Therapists, Pharmaceutical Employees, Psychiatric Social Workers, Public Pharmacists, and Hospitals Almoners; the Hospital and Welfare Services Union; the Mental Hospital and Institutional Workers' Union; the Mental Health Workers' Association; the National Association of Administrators of Local Government Establishments; the National Association of Women Pharmacists; the National Union of Public Employees; the Public Dental Service Association; the Socialist Medical Association; the Society of Physiotherapists; the Society of Radiographers; the Women Public Health Officers' Association; and several additional associations of therapists.
40. PRO, MH/107, Health Workers' Council, Memoranda of a deputation to the Ministry, 20 March 1945.
41. Labour Party, ANNUAL REPORT, 1945; Murray, pp. 70-73; Alan Bullock, THE LIFE AND TIMES OF ERNEST BEVIN, Vol. II (London: Helnemann, 1967) Chapter 12.
42. Calder, pp. 660-662. The delay was due to the collection of armed services ballots.
43. Murray, p. 73.

CHAPTER 7

1942 to 1945:

THE LONG NEGOTIATIONS AND REVISIONS, TO

THE LAST WORD OF THE CARETAKER GOVERNMENT

The British Medical Association and the British Hospitals Association were quick to react to the White Paper. One of the first steps of the BMA was to commission the British Institute of Public Opinion to send a questionnaire to all BMA members regarding the detailed proposals of the White Paper. (1) The responses of the approximately one-half of the members who replied were released in August. They were tabulated by age and type of practice, and showed a substantial lack of unanimity in the profession. A good deal of support, for example, was shown among younger doctors for salaried or part-salaried practice in health centres, for an entirely free, comprehensive, universal service, and for larger areas for hospital administration. Control or direct employment by local authorities or joint authorities, however, met with very little favour.

In March 1944 the BMA issued an analysis of the White Paper according to a set of inviolable general principles approved by its Representative Meeting in September 1943. This was followed with a draft statement of policy intended for discussion throughout the country prior to the 1944 Annual Representative Meeting in July. (2) One of

these principles, in direct opposition to the White Paper and to the commitments of Ministers Brown and Willink, was a recommendation for coverage of only ninety per cent of the population, meaning, in effect, an extension of National Health Insurance to cover by means test the poorest ninety per cent, with inclusion of dependents, leaving the wealthiest ten per cent to make entirely private arrangements.

In searching for an explanation for the BMA's "sudden hysteria over the alleged threat to the freedom of medicine," Lindsey concludes, along with the NEW STATESMAN, that the reasons could only have been monetary.

Although not a trade union, [the BMA] was impelled by a desire to protect the economic and professional interests of its members. It favored, for example, maternity clinics and a school medical program for examination and educational purposes but not for therapy. The inclusion of medical treatment would obviously diminish the opportunities for private practice...

'As soon as the government made clear its intention of providing an all-round service for all comers, this section of medical opinion became irreconcilable; it would have picked every possible hole in any "universal" scheme.' (3)

Dissension left the profession without a positive program, and their leaders took negative positions on issues that once appeared to have wide support. It was only on the issue of remuneration that the doctors were able to achieve a large degree of solidarity. As in 1911, they believed that a general policy of opposition to the proposals of the government offered the best hope for good financial terms. (4)

One of the first BMA reactions to the White Paper came from Lord Dawson, then President of the Association. He referred to it, charitably enough given the public campaign to follow, as a "statesmanlike endeavour" in a difficult situation, but noted the BMA was not happy with the hospital proposals, preferring to see the voluntary contributory schemes retained and an equal partnership with

municipal hospitals established. In a speech slightly later to Conservative MPs, Lord Dawson suggested that health centres would create a salaried general practitioner service in which doctors would become a "profession of mediocrities" in the Civil Service pattern. (5)

Reaction of the Voluntary Hospitals Associations

The British Hospitals Association held a Conference of Voluntary Hospitals in London, in early March, to consider the White Paper. The BHA conference, in two resolutions sent to the Minister, indicated general approval of the aims of a co-ordinated hospital and consultant service for all regardless of income, but demanded a more suitable partnership between voluntary and local authority hospitals. The BHA found the financial proposals unacceptable, in that they afforded only partial payment of voluntary hospitals' expenses for services contracted, while suggesting the gap be filled through voluntary initiative. By offering a free service to all, the BHA complained, public incentive to give or contribute voluntarily would be destroyed. (6)

The King Edward's Hospital Fund for London, a major organisation representing London voluntary hospitals, also made detailed representations to the Minister. An extensive memorandum and statement of principles, sent by the Chairman, Lord Donoughmore, in June 1944, outlined an elaborate alternative administrative structure of five tiers for the hospital system. The Fund rejected the idea of thirty-five to forty joint local authority areas to comprise the national hospital structure, and proposed instead twelve to fourteen large "regions" organised around university teaching hospitals, subdivided into "areas"

according to population. A regional hospitals council would represent equitably both public and voluntary hospitals and meet as a common body. The region would be the planning jurisdiction, and would be fully integrated with central machinery. Areas would be smaller administrative units with several per region, and local hospitals councils would co-ordinate complex services in large cities. While all the levels would represent voluntary and municipal hospitals, the main departure from the White Paper's joint authorities was that they would not be tied directly to local government, which had been long the bane of both voluntary hospitals and the medical profession. The Fund also advocated a Central Hospitals Board, directly under the Ministry but with some independence of action. Payments to contracting voluntary hospitals should be made directly from the Exchequer without intermediary local authority involvement, and on a three- to five-yearly basis. The King Edward's Fund rejected supplementary grants to make up any gaps between the payments for contracted services and total expenses. This it was felt would undermine voluntary support which must be counted on to make up such differences.

The Ministry's internal memorandum evaluating the Fund's plan saw it as primarily a plan for a voluntary hospital service, with maximum independence rather than co-operation, and as separating planning from administrative functions. The Fund had also suggested two grades of surcharged beds, superior public accommodation and wholly private pay beds. This the Ministry would not accept; it was noted that even the BMA was against "intermediate" public beds (i.e., extra payment for superior amenities but free public medical treatment), "on the grounds that this would leave little or no chance of private consulting practice

and would tend to depress the ordinary standard of accommodation in the public service to a 'poor law' level." This was the view the Ministry would take. (7)

The White Paper in Parliament

In March the first Parliamentary debate took place, on a motion by the Minister of Health proposing the health service as one of the pillars of the postwar social structure, along with changes in education, housing and social insurance. The health service, the Minister said, could only be seen as part of a larger programme: "... the process of reshaping the background of individual life in this country ... The health of the nation, the health of every citizen, young and old, is at the very root of national vigour and enterprise, and this should be the scale ... on which our discussions are framed." The Minister stressed the scheme was not state charity for certain groups; it was intended to free individuals from the burdens of ill health and to raise and keep raising the standard of national health.

The Minister outlined the main principles of the service, and their significance in medical care reform. (8)

Speaking in reply for the medical profession, Sir Ernest Graham-Little, MP for London University, admitted the profession had once approved of health centres, but saw the White Paper proposals as devised to put practitioners in a salaried service, which the profession could not support. He opposed the probable end of private practice, regulation of the location of doctors similar to that under Defence Regulations, and the end of contributory schemes.

For the Labour Party and the SMA, Dr Haden Guest welcomed the

proposals, suggesting that health centres would offer more freedoms to practitioners and patients. Despite the BMA's official position, he said, health centres were supported by many doctors, especially young doctors in the armed services. For the TUC, Mr Alexander Walkden also praised the White Paper but noted the lack of reference to rehabilitative and convalescent care, and urged the adoption of Whitley Councils for nurses and other hospital workers. Dr Morgan, MP for Rochdale, suggested central representation for all health workers, criticised the retention of a dual hospital system, and the apparent neglect of social medicine, environmental and health education concerns, and occupational health.

Speakers generally praised the White Paper; critical comments from the Conservative benches applied mainly to the alleged failure to preserve the voluntary hospitals adequately, and to the assumed move to salaried practitioner service. (9)

These latter criticisms represented something of a division in Conservative ranks over the government's apparent enthusiasm for a health service. The Minister, and his Parliamentary Secretary, Miss Florence Horsbrugh MP, attempted to reassure the backbench Tory critics that the government had in mind the best interests of the medical profession and the voluntary hospitals. While largely successful in quelling Tory dissent, they were unable to convince one critic, Major Lloyd, MP for Renfrew, who believed the White Paper to have been written by the hidden hands of Political and Economic Planning (PEP) and Sir William Beveridge.

For the Labour Party and the SMA, Mr Silkin, MP for Camberwell, and Dr Edith Summerskill, Fulham West, offered criticisms from the left. Mr

Silkin opposed maintenance of the sale and purchase of practices and of private practice in the public service. He urged a greater role for the state in the administration of voluntary hospitals and the provision of more convalescent and chronic care facilities. Dr Summerskill saw the White Paper as too much oriented to curative rather than preventive medicine and as placing the interests of doctors before patients; the arrangements for private practice would only accentuate social class differences, and, she said, turn the health centres into centres for second class treatment. Mrs Hardie, an MP from Glasgow, urged the inclusion of dentistry and the integration of the mental health services, and called on Labour local authorities to spend generously on the new health centres and local authority services to make them attractive to doctors and patients. (10)

Thomas Johnston, Labour Secretary of State for Scotland, responsible along with the Minister of Health for the White Paper, ended the debate by emphasising the flexibility of the proposals, especially with respect to payment of doctors and to the arrangements for private practice. He noted that not even in the socialised medicine of the USSR was private practice entirely eliminated, and the British government intended to win the goodwill of doctors through its retention. The resolution welcoming the intention of the Government to establish a comprehensive National Health Service was carried. (11)

Willink's Public Defence of the White Paper

The campaign of the BHA and the voluntary hospitals against the White Paper provisions was launched in earnest following the March debate in Parliament. Between April and June approximately twenty of

the most prestigious of the voluntary hospitals sent their MPs well-organised petitions, or wrote to the Minister. They were reassured by their Members in most cases, in answers provided by Ministry of Health officials, that provisions would not be fixed until discussions had been held in which the BHA would take a full part. (12)

The Minister was obliged to begin a public defence of his hospital and general health service proposals. In April he spoke in Birmingham, reassuring the medical profession and voluntary hospitals that their independence was not threatened. He noted that many hospitals regretted the ending of their contributory schemes, but that to keep them would mean "adapting the end to suit the means, and that we cannot do." A month later he spoke to an invited audience of his Conservative Constituency Association, in Norwood, South London, and several Norwood and Croydon groups, including the local BMA, voluntary hospital, headmasters' and business representatives. He made the same reassurances of independence, but declared that "the need for a scheme is such that obstruction by sectional interests will not be tolerated by public opinion." He also defended the concept of health centres, noting that there was no intention to limit the experiment to one type; rather, the "whole object is to open up new forms of practice with consequent benefit to doctors and the public."

Clearly defending the White Paper against attacks from the left and right, he again explained the flexibility of payment arrangements for doctors (all methods of remuneration would be possible, and salary never obligatory), the important role that local authorities would play in reflecting the personal, local and democratic nature of the service, and the evolutionary development envisioned for the whole scheme. It would,

he stressed, need the enthusiastic co-operation and compromise of all interests. (13)

Willink Begins Discussions with the Three Major Interests

The Minister's hopes, however, were to be frustrated in a continuing battle with the BMA and BHA, in public and in confidential negotiations, through the following year. The apocalyptic nature of the public statements of these two organisations was often in sharp contrast with the businesslike way in which the negotiations proceeded, but the element of struggle was present from the public forum to the boardroom.

Under Henry Willink, before the end of the Coalition government, the formal discussions with the local authorities, the voluntary hospitals, and the medical profession went through two distinct stages: the first, from April to September 1944, after which certain revisions were announced; and the second, from January to March 1945, during which further revisions were made but not publicly announced. A third and perhaps the most significant series of revisions was made in May and June 1945, by the Conservative Caretaker government, following Labour's withdrawal from the Coalition, and pending the July election.

The April to September 1944 Negotiations:

Negotiations with the Medical Profession

The Minister held discussions with representatives of the medical profession in April and August, 1944. In October, he announced proposed changes to them, and to the other two negotiating groups.

At the first of the meetings in April, a lengthy list of questions

prepared by the BMA was discussed. One of the matters of greatest concern, early in the meeting, was that of the precise arrangements for private practice in the hospital and consultant service. The Ministry had made it clear that part-private practice would be allowed, i.e., that a specialist would be allowed to treat his private patients in public facilities, providing the patients paid both a full hospital maintenance charge and the doctor's private fee. Public patients would receive treatment and maintenance free, except for the possibility of introducing so-called "amenity beds", i.e., rooms of a higher standard in the public wards, for which patients would pay a small extra maintenance charge only. This proposal did not rest well with the BMA: "Dr Hill was emphatic that there should be no halfway house, no system of payment for extra amenities within the public service, no system whereby the patient could get, for example, private accommodation with the advantages of a free surgeon." He stressed that such a system would both depress private practice for consultants, and introduce grading of standards in the public service according to ability to pay.

The BMA asked why the White Paper made no proposal to locate all government health services, including industrial, under the Ministry of Health, and why such a large responsibility as housing would not be separated from the responsibilities of the Ministry. No conclusive answer beyond the White Paper statements was given by Ministry officials. The BMA also raised but did not press the issue of administration of the service by a semi-independent professional corporation, and urged measures to expand medical education and to bring about equal opportunity, pay, and conditions for female doctors.

Arguments were raised by the BMA committee in favour of Health

Services Councils, at central and local levels, which would have a majority of representatives elected by the medical profession, and would be free to publish advice and opinions on health service matters. They further wished to see the powers of the Central Medical Board reduced from those proposed; it should not have powers of direction of doctors to practise in designated areas.

The sale and purchase of practices, which might have been expected to be a difficult issue, was at this point approached tentatively, and with little rancour. The BMA committee recognised that the value of practices would fall with the advent of the new service, especially with health centres, hence state compensation for this fall in value was logical. Dr Hill "thought that the right to general compensation must be conceded, and therefore that this would be a good time to consider abolishing sale and purchase altogether and buying out all practices." Dr Dain, the other senior BMA representative, suggested that whether sale and purchase were ended or not, a general evaluation of all practices should soon be undertaken, in preparation. These positions were a strikingly liberal appraisal of the issue, in contrast with the later BMA position.

The BMA representatives stood against the previously expressed positions of the BHA on two issues related to voluntary hospitals. They felt, first, that the hospitals should be paid in full, not just in partial compensation of their expenses, and secondly were glad to see the end of the contributory schemes, since the BMA "fully supported the idea of free hospital treatment for all." The BMA supported the BHA wish to have Central and Local Hospital Services Councils, parallel to the Medical Councils.

With respect to consultant services, the BMA were assembling a Negotiating Committee representing the Royal Colleges, but took the position, in advance, that rates of remuneration should be uniform and determined centrally, and that there should be no incentive for consultants to remain entirely outside the service (apart from allowing part-private practice).

Experiments in health centre planning should be undertaken before any wide-scale central policy was set, the BMA argued, although wide experimentation should be undertaken by the Ministry directly, advised by the Central Health Services Council, and jointly evaluated. In contrast to the Ministry's idea, any non-competitive system of remuneration in health centres was emphatically rejected, although it was suggested capitation fees earned by health centre doctors might be pooled and redistributed according to a method of their own choosing.

At the conclusion of the discussions, the BMA representatives requested official answers to their several questions, especially the issue, which they strongly advocated, of including all separate government health services under one Ministry. The Minister said it would be possible at a future date to discuss concessions, but urged caution in discussions in the interim: "It was felt -- and the doctors agreed -- that even if concessions could be made on some of the main points at issue, it would not be politic to make them all now." The Minister would, therefore, make general replies, and "offer discussion on points where there was likely to be room for concession later." These areas would include compensation, professional representation on planning committees, and the constitution of central and local administrative bodies. (14)

The Minister and his officials met again in August with a larger group of representatives of the medical profession, this time including Lord Dawson and members of the Royal Colleges. Views were exchanged, but no commitments made by the Minister. Dr Dain, for the BMA, again stressed that the profession must find the administrative structure satisfactory, and be satisfied that freedom, and a "proper part for the profession" were secured, as prerequisites to discussing any other questions. Sir Alfred Webb-Johnson advocated a hospital service organised, for purposes of planning, regionally around university teaching hospitals. The Minister, with Lord Dawson, supported the White Paper joint authority concept, but offered to consult with the Cabinet on this and the issue of medical representation on planning and administrative bodies. (15)

By the next meeting, in October, Willink had discussed a number of major changes with his War Cabinet colleagues, including Labour Ministers Attlee, Bevin, and Morrison. The War Cabinet Reconstruction Committee, in early October, had rejected Willink's request to expand the statutory powers of the Central Health Services Council and its medical representation. The Committee suggested it should be enlarged, with broader terms of reference and functional representation from other professional groups. The most significant decision was to authorise the Minister of Health to drop the joint authority proposal of the White Paper, and discuss a regional system of planning, the regions being organised around university teaching hospitals, with the planning authority representing local authorities and voluntary hospitals. The Committee determined that majority representation should go to the local authorities, against the Minister's wish to provide equal

representation.

The Committee also agreed with Mr Willink's request, on behalf of the medical profession, to drop the powers of the Central Medical Board to direct doctors to areas of practice, but decided to retain its power to declare certain over-doctored areas closed to new practitioners (i.e., "negative direction"), and agreed to drop the requirement that new doctors engage in wholly public practice for the first several years. With respect to health centres, the Committee rejected the Minister's request that doctors be engaged only as tenants, or solo practitioners, in the centres: "The health centre experiment [in co-operative practice and teamwork] had great potentialities, and it was important that nothing should be done to weaken this part of the scheme." (16)

This new mandate to the Minister from the War Cabinet Reconstruction Committee was discussed with the representative group of the medical profession the following week. The Minister now announced that the joint local authority regions would be dropped, in favour of a plan much closer to that advocated by the BHA and the King Edward's Fund. It was suggested that approximately ten regions be established, around university teaching hospitals, the regions containing altogether thirty to thirty-five joint authority areas. The medical group gave its approval, providing the medical profession would be represented directly as the predominant partner, at area and regional levels. With respect to the Central Health Services Council, the Minister now proposed several advisory groups, representing hospitals, and the medical, dental, and nursing professions. The doctors agreed to this, providing the advisory groups would have wide autonomy. This, the Minister cautioned them, was

not likely to be acceptable to his colleagues. (17)

Official talks with the medical profession were left at this stage until January 1945, pending the calling together of a formal Negotiating Committee for the profession, and the holding of the BMA's Annual Representative Meeting in December, and a Panel Conference of General Practitioners.

BMA Chairman Dr Guy Dain summed up the decisions of the BMA Representative Meeting as follows:

We have expressed ourselves in favour of the development of the service; we have disapproved of the White Paper as it stands; we have decided to negotiate; we prefer evolution from National Health Insurance; we do not wish to be employed by local authorities nor to be subject to clinical direction, nor do we wish a whole time salaried service for general practice or to be without clinical control. (18)

THE TIMES concluded: "From an impressive mass of negative resolutions, it emerges only that the conference has willed almost all the ends and rejected almost all the means." (19)

This then was the indeterminate state of health service planning at the end of 1944, before the opening of formal negotiations with the medical profession and other two major interests in the new year. (20)

Negotiations with the Voluntary Hospitals

The first official meeting between the Minister and the BHA took place in early August 1944. The meeting was also attended by representatives of the BMA, the Contributory Schemes Association, and the Nuffield Provincial Hospitals Trust (the agency chiefly involved in the wartime Hospital Surveys and a strong supporter of a regional system).

The Minister agreed with the viewpoint presented in favour of

maximum autonomy for voluntary hospitals; he had not intended to establish a "partnership" with municipal hospitals in any legal sense, and hoped to be able to modify his proposals to establish a full and real partnership satisfactory to the voluntary institutions, although he could not support an independent Central Hospitals Advisory Council.

With respect to the region versus joint authority issue, the Minister at this point still felt the joint authority system workable. He had been briefed for the meeting by his officials with a memorandum setting out the case against a three-tier regional planning structure as unnecessary and unduly complicated, and informed the BHA that he was considering some machinery for any problems needing to be co-ordinated among the several joint authorities. Details would have to await further consultation with his colleagues, and further talks with the hospitals association, to which the BHA committee agreed. (21)

The Minister's next meeting with the BHA, in early October, followed immediately the decision of the War Cabinet Committee to authorise discussions based on a regional, teaching hospital-centred hospital scheme. Here the Minister announced, for the first time, that the government would consider a two-tier hospital planning system, of ten large regions for specialised planning, each subdivided into three to four areas for planning and co-ordination of more ordinary hospital services. This scheme the Minister offered as more acceptable to the voluntary hospitals, noting that representation at all levels would be more equal than proposed in the White Paper. He further announced that several central advisory bodies, including one for hospitals, were being considered, but that their autonomy would be limited.

Another meeting with the King Edward's Hospital Fund for London was

held a week later to deliver the new proposals, and the following day again with the BHA committee. The BHA representatives accepted the proposal of hospital regions for consideration, but were now more concerned than previously about the financial arrangements. The voluntary hospitals had originally asked for only partial state funding, the remainder to be made up by contributions, but this had presupposed the existence of contributory schemes. The BHA was now in a dilemma, since it appeared logical that if the health service were to be funded as an all-in insurance scheme, the contributory schemes must go. The Minister suggested the hospitals could still make appeals to the public: "Unless the claim of the hospitals that they enjoy widespread public support for the voluntary system was unfounded--which he did not believe--they had a solid ground for appealing for funds to maintain their voluntary status." The Minister agreed to help the hospitals in presenting their case to the public.

With respect to the manner of state payment to the hospitals, the Minister regretted the BHA's continuing opposition to payments being made via the local or joint authorities. The BHA had maintained that the voluntary hospitals would be tarnished with the Poor Law stigma of being "rate-aided" and wished payments direct from the central government. The Minister maintained that a worse dichotomy would exist if voluntary hospitals were "state-aided" and public hospitals "rate-aided," which would be contrary to the main aim of a single planned hospital system resting on local partnership. (22)

A second round of discussions between the BHA and Ministry officials took place in March 1945, following Willink's January and February talks with the medical profession.

Negotiations with the Local Authorities

Talks with the local authority organisations began in June 1944, with meetings between Ministry officials and the County Councils Association, the Metropolitan Boroughs' Standing Joint Committee, and the Association of Municipal Corporations. While the Ministry stressed flexibility in arrangements for the local authority role in hospital and clinic services, the organisations opposed even a temporary joint authority scheme, preferring a wider, regional, non-executive planning body which would have its plan enforceable by the Minister, but operated by the individual local authorities directly. It was noted by the Ministry that this had been rejected earlier as too weak an authority, and as introducing too many complications. The few matters that did need wider regional co-ordination could be handled through special machinery. University teaching hospitals, they suggested, in opposition to the BHA and BMA view, could be represented on joint authority and local committees, rather than themselves being the centre of the regions. The London Metropolitan Boroughs' Committee, chaired by the influential Alderman Charles Key, later Parliamentary Secretary to Health Minister Bevan, feared the joint authority proposal would mean too great a transfer of power over health and welfare functions from the separate London Boroughs to the London County Council. The Minister promised to discuss this with the LCC and with his colleagues. (23)

By October, Willink had bowed to the almost universal sentiment outside his own Ministry against the joint authority plan. The War Cabinet Committee had approved the new region-area scheme, and Willink announced this to local authority representatives. Municipal hospitals would not be transferred to joint authorities, but would remain with the

major individual authorities, as would the health and welfare and clinic services, which had been the object of much of the local authorities' worries over loss of control of their traditional services. (24)

Additional Considerations by the Ministry

Several matters related to the health service but not included in the 1944 discussions were elaborated in Ministry memoranda prior to the beginning of the much anticipated negotiations with the medical profession in early 1945.

Dentistry was one of these, since it had been excluded from the White Paper, pending the report of the Interdepartmental Committee under Lord Teviot. Based partly on this committee's Interim Report, the Minister now proposed a comprehensive dental service to be inaugurated simultaneously with the rest of the NHS, although limited resources might not permit fully adequate service for some time. The service would be set up along the lines of the practitioner service, guaranteeing freedom of choice for dentists and patients, full-time or part-time practice, and similar representation and contract arrangements for the dental profession. Notably, it was emphasised "that there should be a full trial of the Health Centre method of dental practice" after consultation with the medical and dental professions.

These proposals were agreeably received by representatives of the dental profession early in January 1945. Sir Arthur Rucker, Deputy Secretary in the Ministry of Health, proposed payment to dentists by salary in clinics: "The dentists did not demur; they would wish this salary to be paid by the Central Dental Board rather than the local authority." They opposed any large scale provision of dental clinics

but agreed that dental treatment should be available in health centres. It was agreed that official negotiations should take place on this basis. (25)

Implementation of the White Paper provisions for the Mental Health services was also covered by the Ministry, in discussions with the County Councils Association and the Association of Municipal Corporations. (26)

Likewise, changes in financial arrangements for funding hospitals, for reciprocal payments among regions for utilisation by out-of-region patients, and for general administration of the services now to remain with the local authorities, were dealt with in several year-end housekeeping memoranda. (27)

The Negotiations of the Spring of 1945

The stage was now set for what was expected to be the final round of negotiations with the medical profession and the other groups defined by the Ministry as having a legitimate negotiating role.

The first set of negotiations involved the medical profession almost exclusively. The Minister and his officials met weekly between January and March with the newly appointed Negotiating Committee; these meetings culminated in the preparation of a series of draft memoranda of alternative proposals. The first was produced in early February, revised in late February, and twice revised in March. These changes were consolidated by late April, after discussions with the voluntary hospitals.

The Medical Profession, and the Revised Proposals

The negotiations proceeded from two sets of assumptions: the terms of reference of the Negotiating Committee, particularly the stipulation that agreement should be reached on the administrative structure before proceeding to other aspects; and from the brief given to the two Ministers, Willink and Johnston, by the War Cabinet Reconstruction Committee.

Thus, the issues that dominated the early discussions were the administrative arrangements, and in later meetings, health centres, the hiring and distribution of practitioners, methods of remuneration, and sale and purchase of practices. An issue raised frequently by the medical profession was the inclusion of the whole range of government health services, including industrial health, under the Ministry, along with the concomitant issue of the functional integration of all the separate government medical branches into a co-ordinated service, at all levels. This was a matter of concern common to the medical profession and to the Labour and trade union movements and socialist reformers, but was now pressed with particular vigour by the medical profession.

The negotiations opened in January with the Negotiating Committee returning to their theme of a gradually evolving health service. They urged that the hospital and consultant service be started first, and that non-hospital services (general practice, principally) be added later by extension of National Health Insurance.

The Minister noted in response that both branches of the service would take time to develop fully, but the objective of the government was to establish a fully comprehensive and universal service from the start, designed for "the best advantage of the community as a whole

without any limitations of income, employment, or other irrelevant qualifications."

The point that the general practitioner service should be included only by extending National Health Insurance had also been raised privately by one of the medical negotiators, the President of the Royal College of Surgeons, Sir Alfred Webb-Johnson, who had written to Willink only days earlier. Willink saw it as impossible to build a health scheme with limited coverage alongside a national insurance scheme which would include the whole community, although the new service "should be built up and evolved from the existing system of National Health Insurance and should not be based on new or revolutionary principles."

In response to the issue of integration of all government health services, Willink could suggest only that they should be co-ordinated among the several government departments responsible, and that such major items as housing and water supply, inasmuch as they were related to health, should remain in the Ministry of Health.

Although the government, through the Minister, was clear in making known its commitment to a comprehensive scheme with coverage of the whole population, it plainly did not share the views of the profession and the reformers alike that it would be consistent with these larger aims to bring all separate health services together into a co-ordinated whole. (28)

During the January meetings, the Negotiating Committee were most concerned with the structure of the Central Health Services Council, the chief advisory body to the Minister, and the proposed Central Medical Board, which would be the body with statutory powers over hiring and distribution of doctors.

In his first "Alternate Plan," Willink attained a compromise with the Negotiating Committee over these two bodies. While the medical profession wished to see a single Central Health Services Council, and opposed the BHA's proposal of a parallel Central Hospitals Council, the Minister now proposed that several Standing Advisory Groups, representing the medical and dental professions, the hospitals, and perhaps other interests, be set up to work in conjunction with the Central Council. In deference to the medical profession, the Central Council would be primarily medical, with some representation of other interests, while the Standing Groups would represent exclusively one profession or interest. The Central Medical Board, in another concession to the medical profession, would lose its proposed power to require full time public practice for the first several years of a doctor's participation in the health services, and its power to direct doctors to certain areas by prohibition or incentive.

The Minister would not concede the medical profession's demand that Regions be given statutory executive and financial powers. These powers would rest with the Areas, made up of local authorities. Thus there would be about ten Regions, the central institutions of which would be university teaching hospitals. They would have expert advisory, co-ordination and planning duties, presenting their plans for the regional health services to the Minister in consultation with (but not necessarily in agreement with) their constituent Areas. The Areas, which would total about thirty-five, would be based on the original Joint Authority proposal, i.e., combined local authorities, which would have executive and financial powers, and planning duties, for the services in their local authorities. The Area Councils would in

addition be the democratically responsible level, with majority representation from the local authorities (including municipal hospitals) and a combined minority representing the medical profession, voluntary hospitals, and others to be determined (e.g., dentists, pharmacists, nurses).

Below this, the County and County Borough Councils would be responsible through Statutory Health Committees in each local authority for administration and operation of the maternity, children's, home nursing and other services, including the maintenance and staffing of the planned health centres.

The general practitioner service would be operated by committees adapted with little change from the National Health Insurance local committees, with statutory powers and majority representation of the local medical profession. These local committees would probably become the contracting bodies for general practitioners, in order to satisfy the medical profession's rejection of any direct contractual relationship with local authorities.

Remuneration standards would be set according to the Spens Committee's recommendations, while the method would be determined in consultation with the profession, with the possibility of part-salary, part-capitation being the basis. The Minister clearly wished at this point to retain salaried remuneration as an open option: "The views of the profession would also be welcomed on the possibility of providing salary as an alternative to capitation in suitable circumstances at the option of the individual doctor." Health centres might have a basic part-salary with the remainder of the capitation-based income pooled and distributed according to the agreed wishes of the doctors in the centre,

with a certain deduction for use of the health centre facilities.

Free choice of doctor by patient would be guaranteed, as well as the choice by the doctor to treat any patient privately. Access to consultants would be through referral by a practitioner, who would have the greatest possible choice of consultants at his disposal. The patient, in turn, would have free choice of public or private treatment or a mixture. (29)

To these positions the Negotiating Committee took objection on the grounds of dilution of medical power implied in the proposal for Standing Advisory Groups to the Central Health Services Council, and the lack of right of the Council and the Groups to publish opinions independently; the latter point the Minister agreed to reconsider. He declined, however, to concede added statutory powers to the Regional Councils, since they would not in any case be responsible to the public through normal democratic machinery.

The first revisions to the Minister's Alternate Proposals in February 1945 concerned primarily the central machinery. The Standing Advisory Groups would remain, but, at the request of the profession, medical representation would be increased and the Groups would have direct access to the Minister. With respect to local arrangements, the objective of using National Health Insurance machinery as much as possible would be emphasised, the method favoured by the BMA. No changes were made in proposals for health centres, remuneration, or private practice and freedom of choice, but it was decided that consumer or lay representatives, appointed by the Council and the Minister, could be added to the local medical committees. (30)

The amendments were generally acceptable to the Negotiating

Committee, which was now satisfied the government did not intend to dilute medical influence through the Standing Advisory Groups. Argument was still raised, however, over the lack of statutory planning and financial power for the Regions, a point on which the Ministry would not give ground, except to reassure the Committee that the interests of the profession, including the consultants at the regional level, were well safeguarded.

Discussion went on to the general practitioner service. The profession would accept health centres, on a trial basis, providing the experiment would be widespread and controlled centrally, to which the Minister agreed. The Negotiating Committee displayed some disunity on the issue of part-salaries, some members wishing removal of any reference to salaries in future health service discussion documents, and others favouring part-salaried partnerships. The Ministry was not willing to rule out part-salaries at this point.

The medical negotiators were opposed to ending sale and purchase of practices, but wished an early statement of government intent. In a lengthy discussion on this topic at the subsequent meeting, Sir Arthur Rucker, for the Minister, noted the difficulties with any of the alternatives to abolishing sale and purchase. In particular, there was much public antipathy to the sale and purchase of the "goodwill" of patients; in addition, it posed a large financial barrier to young doctors setting up practice; and it was plainly incompatible with a public health service. The medical representatives, although not unanimous, preferred a general abolition, with compensation, to any gradual or partial compromise. They did also, at this time, request the removal of any reference in the Ministry's Alternate Proposals to

payment by salary or part-salary. They agreed, however, to the pooling and redistribution of capitation fees in health centre practices. (31)

The second revision of the Minister's Alternate Proposals, unveiled to the Negotiating Committee in late February, clarified and formalised the composition and power of Central, Regional, Area and Local bodies. It added Regional representation to Area level meetings, and general practitioner representation to local hospital committees. Health centres were "to be the subject of centrally controlled experiment with different types of centre." Despite the doctors' request, however, no change was made in the health centre part-salary remuneration proposal, and on the difficult question of sale and purchase the problems were described but no policy announced.

In the meeting following the second revision of his proposals, the Minister requested the views of the profession by late April, so that the Parliamentary Bill could be framed; any matters undecided by then could be left for later discussion and regulations, or amendment in Parliament. The views of the BHA and local authorities were also being solicited on the basis of the second revision of the proposals.

The Negotiating Committee again reiterated points made in earlier discussions: in particular that the Minister of Health should be concerned with all government health matters, and only with health; that the scheme should be implemented gradually, in stages; and that the profession doubted the value of a scheme covering the whole population. The Minister in reply reconfirmed the government's commitment to a universal and comprehensive scheme, and, while noting the widespread opinion in favour of integrating industrial and similar health services, pointed out the "considerable danger of delaying action on the main

problems if this point were pressed at the present stage." The Committee also requested still more medical representation on the Central Committee, to which the Minister could not agree, and now considered the proposal for a Central Medical Board dispensable, with which he did agree. It was also agreed that the Minister should provide a statement on sale and purchase, and the revised proposals, prior to a BMA Council meeting in late March, which would be the last before the BMA Annual Representative Meeting in May. (32)

In the third revision of the Alternate Proposals, therefore, the Central Medical Board was dropped (unless later requested by the profession), and all other matters were left unchanged apart from the requirement that the "health centre experiment" be planned with the advice of the medically dominated Central Health Services Council (as requested by the profession), and the guarantee that practitioners in health centres would have no direct contract with the local authorities, which would provide all ancillary staff and maintain the centres. The issue of sale and purchase was once again left undecided. (33)

The penultimate meeting of the Negotiating Committee with the Minister took place in late April, a month after the third revision of his proposals had been produced, during which time he had consulted with the local authorities and the voluntary hospitals, and had received deputations from the TUC and the Health Workers' Council.

Willink now confirmed that even the Area Councils would have no power over the distribution of practitioners; only the Local Committees would have authority to hire doctors. This meant, in essence, that any effective Central, Regional, or Area influence over the distribution of medical practices had been given up to entirely local medical

prerogative; the Area Council (with largely local authority representation) would have only advisory power.

Despite confidence expressed by Ministry officials that the part-salary proposal could only be beneficial to general practice, Dr Charles Hill asked that "payment by salary should be ruled out as opposed to the principles of the profession." "The profession did not accept the view that financial competition between practitioners in a health centre was inadmissible," he said, and believed that "co-operation in work (which was accepted as essential) did not necessarily depend on financial partnership."

The Committee made a final attempt to enhance the status of private practice by requesting that grants-in-aid be made available to persons seeking private treatment in hospitals. Sir Arthur Rucker, for the Minister, again pointed out that such a scheme would be appropriate only in an insurance-based system, not in a comprehensive public service financed by taxation.

While other local administrative details were settled, the question of sale and purchase, with which the government was having a great deal of trouble, remained unresolved. (34)

This then represented the substantial progress of negotiations with the medical profession prior to the BMA's Annual Representative Meeting, and the end of the Coalition government in May. Through the successive revisions of his alternate proposals, the Minister had conceded greater administrative, advisory and planning powers to the medical profession, and had removed any effective power over distribution of general practitioners.

He had, however, retained the initial democratic and egalitarian

principles of the White Paper -- that the service should be universal and comprehensive, and that its local and central administration should be based on existing levels of elected government.

Discussions with Hospitals and Local Authorities Groups

The Minister's revised proposals were received relatively agreeably by the British Hospitals Association and the King Edward's Hospital Fund for London. They were satisfied with the proposal for a Standing Hospitals Advisory Committee to the Central Health Services Council, providing it had power to intervene in any Area-level disputes regarding voluntary hospitals. They approved in general the financial details, and were agreed that the future of contributory schemes could be discussed later, along with questions of the amount and procedure of government finance of the hospitals. These views were made known in several meetings with the Minister and were ratified by a Conference of Voluntary Hospitals in late March. (35)

Discussions with the local authorities, one must assume from the scanty evidence in the Ministry's file, went relatively successfully following the Minister's major decision to drop the Joint Authority proposal, which would have entailed transfer of control of municipal hospitals and clinic services from individual to combined local authorities. They were satisfied with the majority representation on the Area Committees, and the statutory planning and financial powers, and with the retention of municipal hospitals and clinic services. Only the matter of health centres proved troublesome, because of the divided jurisdiction among central planning, local staffing and maintenance, and the general practitioners who would practise in the centres but who

wanted no contractual relationship and minimal contact with the local authorities.

In the Ministry's March 1945 summary of discussions with the local government groups, it was noted that factors were weighted against the success of the health centres, for the above reasons, and that some authorities were cautious, fearing blame for their possible failure. But most authorities were optimistic about the long-run prospects, allowing the Ministry to conclude that, despite negative indications, "it is probable that the health centre system of family practice, particularly in urban areas, will improve the practice of medicine out of all knowledge, and this prospect of providing a really first class family doctor service should not be abandoned because of present-day difficulties." (36)

Deferral of the Issue of Sale and Purchase

Policy on the sale and purchase of medical practices was an issue with which the government still had particular difficulty, as evidenced by the long delays in making a statement, despite the urgent requests of the medical profession. It would appear that considerable differences of opinion existed, on the one hand between the senior officials of the Ministry of Health and the Secretary of State for Scotland, who favoured early and full abolition of sale and purchase with compensation, and the Minister of Health on the other hand, who appeared to be voicing the same doubts (although not absolute opposition) as those expressed by the medical profession. It was also clear that the SMA, the Labour Party, the MPU, many young doctors, and much of the public favoured immediate abolition of sale and purchase.

Accordingly, the matter was brought before the War Cabinet Reconstruction Committee by the Minister, in order to acquire some indication of government policy before the BMA's Representative Meeting in early May. Willink recommended the government defer any decision on the continuation of sale and purchase until the service had been in operation for several years. He felt the extra upheaval of abolition would be unnecessary and not productive for the profession, and that the government should provide some assistance for young doctors leaving the forces to enter new practices. The Secretary of State for Scotland proposed a Committee of Enquiry to make an early recommendation on future policy. All members were agreed that compensation must be part of any abolition of sale and purchase, but opposing views had been expressed on whether the new service would increase or decrease the value of practices. In two Reconstruction Committee meetings, it was decided to defer a decision, pending several years of experience and an enquiry, that a statement should be made to this effect, noting the case for abolition and the problems it would cause, and that the government would seek the profession's advice on facilitating young doctors' entry into practice. The Bill, which was expected to be ready for consideration in May, would therefore contain no definite policy.

Lord Woolton, Minister of Reconstruction, informing Prime Minister Churchill in late March of progress to date, noted the decisions of the War Cabinet Reconstruction Committee. His Labour colleagues, he said, would have preferred that all practices be bought outright by the state, but they were finally persuaded to make unanimous the Committee's decision to defer the matter. To this decision the Prime Minister gave his approval, for announcement in the House of Commons on 4 May, while

the BMA conference was in session. (37) Willink at the same time obtained the approval of Ernest Bevin, Minister of Labour and National Service and one of the Labour members of the Reconstruction Committee, to make the Commons announcement on sale and purchase. Willink stressed the urgency of reaching agreement on the proposals, so that the scheme "may be settled in a Coalition Bill and not left until after the election." (38)

Response from the BMA: The Annual Representative Meeting

Thus it appeared by early May 1945 that the proposals of the Coalition government were settled, and that it now remained only for their ratification by the BMA Annual Representative Meeting to prepare a Bill based on the Minister's revised Alternate Proposals.

The BMA conference took place on 3 and 4 May. It passed some forty-seven resolutions concerning the health service, the chief among which committed the Association to general approval of the Minister's revised scheme "as a workable basis of the new Health Service" subject to satisfactory negotiations on details. Several additional points remained to be settled, including: statutory powers for the Central Standing Advisory Committees; the integration of all local health services without local authority domination; and more medical representation on the Regional Councils, on the Area Councils, and on the hospital planning groups. In health centres, doctors "should work in free association, renting the premises from the particular authority." BMA Divisions should have a voice in any decision to expand the provision of health centres.

The Association again went on record opposing a basic part-salary;

opposing any limit on professional income; urging "constant collaboration" among consultants and specialists, doctors in local authority, education, industry, and general practice; requesting that the right of patients to private treatment be clearly expressed in the legislation; and, significantly, accepting a scheme of universal (one hundred percent) coverage providing there were safeguards (grants-in-aid were again suggested) for private practice. Negotiations should continue on outstanding issues, but the BMA resolved to take no decision on approval or disapproval until after resolving the issues of: disciplinary machinery; control of certification; safeguards for private practice; and figures for remuneration and for compensation.

The BMA was perhaps at one with the SMA in criticising the scheme for falling far short of the organisation required for a truly comprehensive national health service: "It does no more than provide one branch of such a service--that of personal medical treatment. It fails 'to bring the country's full resources to bear upon reducing ill-health and promoting good health in all its citizens' (White Paper, p. 5)." A "Health Cabinet," consisting of all Ministers responsible for matters having a bearing on health, was suggested as one possible way of achieving this aim of the White Paper.

Thus the same Association which had recently spent several months in negotiation with the Minister attempting to reduce the power of elected and public authorities in favour of greater powers for local and central medical committees had, by the end of its 1945 conference, again taken what appeared as a cautious, conservative and nearly monopolistic view of the medical and administrative arrangements, while at the same time publicly taking a magnanimous position in favour of a service

broadly conceived to further preventive and positive health, and in favour of full integration and co-ordination of all separate health services. (39)

The Caretaker Government: The Unpublished White Paper

May 1945 was to be an eventful month for even greater reasons than the apparently ambivalent stance of the BMA, at what then appeared to be the juncture immediately preceding health service legislation.

The Coalition government was dissolved 23 May following rejection by the Labour Party Annual Conference of Churchill's offer to continue the coalition arrangement until the war in the Pacific ended. Labour and the Liberals had proposed an October election, which Churchill rejected. While Clement Attlee and Ernest Bevin were prepared to accept Churchill's offer, the National Executive Committee and virtually the entire Labour Conference were not; Attlee was obliged to communicate this lack of mandate to the Prime Minister. Churchill accordingly resigned, and was asked within hours by the King to form a temporary government, until the dissolution of Parliament 15 June. The Commons, meanwhile, reassembled under the now predominantly Conservative Caretaker government on 29 May. (40)

The final discussion between Willink and the medical profession took place 24 May, the day after Churchill's resignation. It was clear that an election would be held and that further progress with negotiations would be impossible; the Minister did not know what course would be adopted with respect to legislation by the Caretaker government in the short period before the election on 5 July. (41)

Willink moved quickly, however, to have a draft White Paper,

"Progress with Proposals for a National Health Service," prepared by early June for possible use in the election. It was presented to Cabinet, on 4 June, by the Lord President of the Council, who suggested its use, prior to the election, as a "desirable indication to the public of the government's intentions." The draft White Paper affirmed that all the main principles of the 1944 White Paper would be retained: the ends were the same but some of the means would be altered. The detailed changes resulting from several months of negotiations were enumerated.

(42)

Despite the recommendations of Lords Woolton and Cherwell to Prime Minister Churchill in favour of publication of the new White Paper, the Cabinet took the advice of the Minister of Health and the (now Conservative) Secretary of State for Scotland against publishing. They suggested the Cabinet approve the changes outlined, and make only a general announcement, which would, on the basis of the negotiations and concessions, be supported by a great majority of doctors, the voluntary hospitals, and the associations of local authorities (with the exception of the London County Council).

In Cabinet on 15 June, the Minister of Health argued that government candidates in the election should have the most recent position available, since much progress had been made in negotiating issues originally objectionable to some groups. With the support of the Prime Minister, who urged emphasis on the improvement to the standard of general practice, the Cabinet decided to agree to the Minister's proposed changes, and to have speech material and a government announcement prepared for release the following week. This material was sent by Willink to Churchill on 16 June for his approval.

On 18 June, Churchill, writing to Willink, expressed approval of the changed health service proposals, but now doubted the need for any announcement, feeling the Opposition would attack any changes as a betrayal of the White Paper: "The only question is how well [the new proposals] strike the electors at this juncture." Commenting on the extent of the Prime Minister's interest in the scheme, Calder notes that: "Churchill, much to his irritation, had to apply himself hastily to the concoction, on the advice of his ministers, of plausible policies in such fields as the health service, in which he had little interest." (43) He urged Willink to see Lord Beaverbrook for final advice on whether to make a public announcement.

Willink, after seeking advice, notified Churchill on 19 June that he would make no statement until the Opposition attacked; only then would he make the general announcement approved by Cabinet. (44)

The Labour Party manifesto, "Let Us Face The Future," on the other hand, contained the SMA-Labour policy which was passed at the Labour Party Conference of December 1944 and ratified again at the Conference of May 1945. The Labour Party thus went to the electorate relatively well-prepared both with its own detailed policies, and on the basis of its part in the development of the Coalition proposals.

Polling day was 5 July, and the Labour landslide was confirmed when the votes were counted 26 July. Churchill immediately tendered his resignation, and Clement Attlee became Prime Minister of a Labour government charged with the implementation of much of the Coalition reconstruction plans, including the National Health Service.

The Coalition had set a very clear pattern in the representation of interests, concentrating on the three major or established interests --

the medical profession, the voluntary hospitals, and the local authorities -- those interests which dominated aspects of the production and distribution of medical care. Of these three (with the minor exception of the London County Council), only the medical profession was not entirely satisfied, since the Coalition had defended its original principles of comprehensiveness and universality against the BMA's demands. In the administrative and contractual aspects of the health service, all three blocks of interests were satisfied.

It is clear from discussions in the Caretaker government, that the Labour Ministers did indeed have some influence on the Coalition's early plans, but that these were accepted under duress, particularly the health centre provisions.

It appeared clear that certain of the key issues of the Labour movement and the advocates, particularly the reorganisation of general practice in health centres, the provision of industrial health services, and the integration and co-ordination of all aspects of the NHS, would stand little chance under the Coalition. Several principles, in particular integration, had been sacrificed to serve one or another of the major interests.

Thus it remained to be seen whether the new Labour government, taking over the state with an enormous electoral mandate, with well-developed health service policies and the close liaison of an expert socialist medical group, and with the massive backing of the Labour movement, would alter significantly the policy course charted, and compromises conceded, and the pattern of representation of interests established by the Coalition government.

CHAPTER 7 — FOOTNOTES

1. Eckstein, pp. 143-147 describes the BMA's panic reaction to the government's intention to act, and its perception of a serious threat to private practice. See also Lindsey, pp. 36-41.
2. Ross, pp. 86-89.
3. THE NEW STATESMAN AND NATION, 31 (1946), p. 233, quoted in Lindsey, p. 41.
4. Lindsey, p. 41.
5. THE TIMES, 19 February 1944, p. 2, and 8 March 1944, p. 2.
6. PRO, MH 77/100, Representations by Voluntary Hospitals 1943-1946, Correspondence and resolutions sent to the Minister by Sir Bernard Docker, Chairman of the Council of the BHA, 7 March 1944.
7. PRO, MH 77/100, Correspondence and memoranda from King Edward's Hospital Fund for London, April and July 1944, and associated Ministry memoranda.
8. 398 HC Deb. 16 March 1944, H.U. Willink, cols. 427-432.
9. 398 HC Deb. cols. 439-486.
10. 398 HC Deb. cols. 535-597.
11. 398 HC Deb. cols. 619-632; THE TIMES, 18 March 1944, p. 8.
12. PRO, MH 77/76, Voluntary Hospitals Representations, 1944.
13. THE TIMES, 15 April 1944, p. 2; PRO, MH 77/31, Minister's Speech in Constituency, 17 May 1944.
14. PRO, MH 77/30B, White Paper Discussions, Reports of Meetings with Dr Hill and Dr Dain, 4, 11 and 12 April 1944; NHS (44) 2, 3, and 4, Minister's Official Replies to the Representative Committee's Questions; see also Willcocks, pp. 52-56, 63-68, 78-82.
15. PRO, MH 77/30B, Report of a Meeting with a Small Group from the Medical Profession, NHS (44) 10, 4 August 1944.
16. PRO, Cabinet Papers, CAB 87/6, War Cabinet Reconstruction Committee Minutes, R. (44) 65th Meeting, 2 October 1944.
17. PRO, MH 77/30B, Report of the Second Meeting with a Small Group from the Medical Profession, 10 October 1944.
18. Quoted in Goodman, p. 119.

19. THE TIMES (n.d.), quoted in Goodman, p. 119.
20. Willcocks, pp. 55, 67, and 81-82, discusses the reactions of a variety of groups to this so-called "Willink Plan" of 1944-45, and some of its more detailed administrative provisions.
21. PRO, MH 77/30B, NHS (44) 9, Report of Meeting with British Hospitals Association, 3 August 1944; and NHS (44) 8, Memorandum, "The Joint Authority and Hospital Services."
22. PRO, MH 77/30B, NHS (44) 13, Report of Meeting with the British Hospitals Association, 5 October 1944; NHS (44) 15, Report of Meeting with King Edward's Hospital Fund, 17 October 1944; NHS (44) 16, Report of Meeting with the British Hospitals Association, 18 October 1944.
23. PRO, MH 77/30B, Reports of Meetings: NHS (44) 6, County Councils Association, 14 June 1944; NHS (44) 7, Association of Municipal Corporations; NHS (44) 11, Metropolitan Boroughs' Standing Joint Committee, 22 August 1944.
24. PRO, MH 77/30B, Reports of Meetings: NHS (44) 17, Association of Municipal Corporations, 19 October 1944; NHS (44) 18, County Councils Association, 26 October 1944.
25. PRO, MH 77/30B, NHS (44) 19, "Dentistry in a National Health Service; Some General Proposals for Discussion"; NHS (45) 2, Report of an Informal Discussion with Dental Profession Representatives.
26. PRO, MH 77/30B, NHS (44) 21, "Implementation of the White Paper Policy in Respect of the Mental Health Services," 7 December 1944.
27. PRO, MH 77/30B, NHS (44) 20, "Suggested Arrangements for Service and Customer Payment and for Exchequer Grant"; NHS (45) 1, "Financial Provisions," January 1945.
28. PRO, MH 77/119, Negotiating Committee (Medical Profession) 1944-1965, Correspondence from Sir Alfred Webb-Johnson to H. Willink, 8 January 1945; and NHS (45) 3, Minutes of Meeting with the Negotiating Committee, 12 January 1945.
29. PRO, MH 77/119, NHS (45) 8, Notes on Recent Discussions with the Negotiating Committee of the Medical Profession, and Appendix, The Alternate Plan, 3 February 1945.
30. PRO, MH 77/119, NHS (45) 8, First Revision, 6 February 1945.
31. PRO, MH 77/119, NHS (45) 20, Minutes of Meeting with Negotiating Committee, 20 February 1945.
32. PRO, MH 77/119, NHS (45) 8, Second Revision, 23 February 1945; and NHS (45) 30, Minutes of Meeting with Negotiating Committee,

13 March 1945.

33. PRO, MH 77/119, NHS (45) 8, Third Revision, (approx.) 20 March 1945.
34. PRO, MH 77/119, NHS (45) 39, Minutes of Meeting with Negotiating Committee, 24 April 1945.
35. PRO, MH 77/100, NHS (45) 16, "Notes on Recent Discussions with the British Hospitals Association" with Appendix of the Minister's Alternate Proposals, 28 February 1945; Minutes of Meetings with the Minister, 22 February and 16 March 1945; and BHA Report of Conference of Voluntary Hospitals, 23 March 1945.
36. PRO, MH 77/30B, Memorandum on Discussions with the Local Authorities, March 1945.
37. PRO, Cabinet Papers, CAB 87/10, War Cabinet Reconstruction Committee Minutes, R. (45) 12th Meeting, 12 March 1945; R. (45) 13th Meeting, 20 March 1945; PREM 4-36/3, Memorandum From Lord Woolton to Churchill, 26 March 1945; Memorandum from Churchill to Lord Woolton, 4 May 1945.
38. PRO, MH 77/119, Correspondence, Willink to Ernest Bevin, 26 April 1945, and Bevin to Willink, 28 April 1945.
39. PRO, MH 77/119, N.C. 32, The Negotiating Committee: Resolutions Passed by the Representative Body of the BMA, 3 and 4 May 1945.
40. Calder, p. 662.
41. PRO, MH 77/119, NHS (45) 45, Minutes of Discussion between the Minister and the Negotiating Committee, 24 May 1945.
42. PRO, PREM 4-36/3, C.P. (45) 13, Memorandum to Cabinet on a National Health Service by the Lord President of the Council, 4 June 1945, with proof copy of draft White Paper, "Progress with Proposals for a National Health Service," June 1945.
43. Calder, p. 663, for Calder's discussion of the 1945 election, see pp. 660-674; see also Alan Bullock, *THE LIFE AND TIMES OF ERNEST BEVIN*, Vol. II, (London: Heinemann, 1967), Chapter 12.
44. PRO, PREM 4-36/3: letter from Lord Cherwell to Churchill, 5 June 1945; C.P. (45) 32, Memorandum to Cabinet by the Minister of Health and Secretary of State for Scotland, 11 June 1945; C.M. (45) 9th Conclusions, Minutes of Cabinet Meeting 15 June 1945; Memoranda from Willink to Churchill 16 June 1945, from Churchill to Willink 18 June 1945, and from Willink to Churchill 19 June 1945.

CHAPTER 8

THE HEALTH SERVICE PROPONENTS:

THE SEARCH FOR A SOCIALIST HEALTH PLAN

The pre-White Paper campaign of 1943, which began very much on the offensive to publicise the policies of the proponent groups, had turned in essence, in 1944 and 1945, into a defense of the White Paper proposals, which the groups believed were the best to be expected from the Coalition. Now, however, Labour had won the election in a landslide, and there was optimism that what was believed to have been lost in the course of Willink's last round of negotiations with the 'vested interests' under the Caretaker government might indeed be regained by starting afresh, with Labour's much reaffirmed Conference policy on a National Health Service. The SMA, for example, pointed out before the election that:

"Only the return to power of a Socialist government can give the people what they so much desire, a complete service staffed by whole time salaried officers, able to give the very best possible service; a service of which the scope, quantity and quality is determined by the people themselves, advised by doctors who are free from restrictions which the present economic basis of medicine places upon them." (1)

In Prime Minister Attlee's 4 August 1945 announcement of his new government, Aneurin Bevan was named Minister of Health, which included responsibility for housing. "The extraordinary nature of the commission

with which Bevan was charged must be emphasized," says Michael Foot: "it was nothing less than to persuade the most conservative and respected profession in the country to accept and operate the Labour Government's most intrinsically Socialist proposition." (2)

This energetic member of the Labour backbench, MP for Ebbw Vale, outspoken left wing critic of the Coalition and of the Labour Party and TUC leaderships, adhered to political views which were, in Michael Foot's terms, a grafting on of the philosophies of the Levellers and the Chartists to his own studied Marxism. (3) But he was also a committed defender of Parliamentary methods.

The SMA in particular had high expectations of the new Minister. Bevan, like the SMA, had been identified with the left wing of the Labour Party; his background, in a Welsh mining area, left him with a great concern for the health of the people and a great dislike for privilege and vested economic interests. His independence and his socialist views had led him into deep conflict with both Labour parliamentary leadership and TUC leadership in the past.

Of the 393 Labour MPs in the new Parliament, twelve were members of the SMA. Of these, the most senior were: Mr Somerville Hastings, President of the SMA and long influential in its activities in addition to being Chairman of the London Hospitals and Medical Service Committee; Dr H. B. Morgan, Medical Advisor of the TUC; Dr Stephen J. L. Taylor (later Lord Taylor), formerly Assistant Editor of the LANCET and Director of the Home Intelligence Division and Social Survey of the Ministry of Information, who had earlier been called upon for advice by Health Minister Willink; and Dr Edith Summerskill, Parliamentary Secretary to the Ministry of Food. (4) Somerville Hastings became

Chairman of the Parliamentary Labour Party's Health Group.

The Proponent Groups Approach the New Minister

The SMA lost little time in making official contact with Aneurin Bevan, assuring him of the Association's willingness to "assist in any way possible" in the implementation of the health service. They advised him that the real views of the medical profession, as shown by the BMA Questionary, had been misinterpreted by the group of senior doctors who had negotiated with Mr Willink. Eight SMA pamphlets and memoranda, on various detailed aspects of SMA health service policy, were forwarded immediately to the new Minister. In September 1945 the Association requested to send a formal deputation to Bevan on the urgent matters of the future of sale and purchase of general practices and provisions for demobilised doctors. The deputation, however, was delayed by the Minister until mid-January 1946. (5)

The Medical Practitioners' Union, in an effort to make an early contribution to a Minister they felt would be sympathetic, similarly requested in September and November to see Bevan; they were not received until late January 1946. (6)

In August 1945, the TUC General Council sent Bevan, with a request to send a deputation, an extensive memorandum reconsidering the positions reached at their last discussion with Willink. The TUC's concern now was to press for features basic to their own conception of a health service, features serving the interests of their own members and of the general public, which they were afraid Willink might have conceded to the medical profession.

The TUC thus called for the abolition of sale and purchase of

general practices; the establishment of health centres in accordance with public demand (with no retrenchment to a limited scheme) and the provision of a full-salary option for doctors, at least in health centres. They commented on the anti-salary position of the BMA: "Having regard to the claim by the doctors that they should be free in practically everything, it does not seem unreasonable to suggest that a doctor should be free to accept a full-time salary if he so desires."

(7)

It was decided after some discussion in the Ministry that the General Council should be asked to send a deputation only after the Cabinet had decided the main structure of the health service; this decision was reviewed and reaffirmed in October and late November. As a result, neither the TUC nor the other major proponent organisations would be consulted directly in the drawing up of the main features of the new scheme.

The trade union movement in general, apart from the TUC, meanwhile stressed to Bevan its strong belief in the principles of the White Paper, largely out of fear that Labour's planning for the health service might start where Willink's planning, and assumed concessions, had ended. The Tobacco Workers' Union argued against concessions; the London Trades Council and the Association of Supervisory Staffs and Engineering Technicians (ASSET) urged the adding of an industrial medical service to the main scheme as had the Royal College of Physicians; the General Federation of Trade Unions and the Scottish Trades Union Congress urged immediate implementation of a unified health service. The Communist Party also took the opportunity to forward its health service policy to Bevan, in October. While accepting many of the

White Paper proposals, including the dual hospital system, they did argue for effective workers' representation in management, for health centres, and an occupational health service. Bevan was advised by one of his officials that the Communist Party did not go as far as the Ministry hoped to go in several aspects of the scheme, and that some of its positions were close to those of the Conservative government. Bevan turned down a request in January 1946 for a meeting with the Party's MP, Mr P. Piratin, on the grounds that it was not appropriate for him to receive party groups. (8)

The Labour Health Workers Group of MPs, recently formed and including Mr Somerville Hastings as Chairman, and Doctors Edith Summerskill and Stephen Taylor, offered their assistance to Bevan, who in reply expressed the hope that their small group would instead join the Parliamentary Labour Party's official Health Committee. (9)

MEDICINE TODAY AND TOMORROW, the newsletter of the SMA, noted the formation of this group, and anticipated that the support it would give Bevan would be as significant as the part played by the SMA, through preparation of Labour's popular health policy, in securing the Labour victory. That policy, the SMA believed, perhaps optimistically, was virtually ready for implementation: "It is probably true to say that no other proposal which the Labour Government has a mandate to carry out is so nearly ready for immediate application." (10)

The several proponent groups, which had all had some role in the development and popularising of Labour Party policy, now looked forward to a role of close consultation with the Labour government in the implementation of a socialised health service for the nation.

The Decision to Nationalise the Hospitals, October to December, 1945

Bevan in fact was moving quickly, in the confines of his Department, to put into effect one of the most significant of the proposals of the SMA. By early October, he had drafted and submitted to Cabinet a plan for a fully unified, nationalised hospital system. This he did without any further recourse to any of the concerned interests. He sought the approval of Cabinet on this major issue of principle, prior to any decisions on the remainder of the NHS.

In a memorandum to Cabinet he noted that the White Paper proposals would have meant the state bearing some ninety percent of the funding of voluntary hospitals, in effect public financing without public control. Local authority hospitals would also have needed substantial Exchequer funds to continue functioning. Both systems provided at best uneven, and at worst very poor service. The joint boards of the 1944 White Paper were unpopular with both the hospitals and local authorities. A nationalised system would be consistent with the goals of the NHS--to provide a comprehensive, co-ordinated, well-distributed service of a uniform national standard, goals which would only be hindered by retaining existing management and finance structures and boundaries. "This seems to me strongly to be a case of starting again with a clean slate." University teaching hospitals would be exempted from a direct relationship with the state for reasons of their exceptional medical and educational standing and their independence. Regional Hospital Boards, appointed by the Minister from medical and local authority nominees, plus others, would be responsible for planning the regional service, and for general administration. District Committees, for "natural hospital districts" centred on a large general hospital or group of hospitals,

would handle day to day administration. Medical staff would be engaged and paid by the boards as agents of the Minister, with advice from regional medical advisory bodies. Some local authority clinic services might be incorporated as hospital outpatient functions, in the spirit of unification.

Bevan expected an outcry from both the voluntary hospitals, whose governing bodies would be abolished and endowments taken over, and from the local authorities, for whom the idea would appear to be "wrenching away the heart of their health services," although some would consider the scheme sound. He felt the reaction of the medical profession was uncertain. Many doctors would be opposed, but would choose a nationalised scheme over one dominated by the local authorities, especially if it were "part and parcel of a well worked out general health service in which they felt that the profession had a square deal." The Minister asked Cabinet for an early decision, so that he could proceed with plans for the rest of the service, and with legislation for that Parliamentary session. (11)

The hospital plan had been designed under Bevan's instructions by his Deputy Secretary, Sir John Hawton, after their first meeting at the Ministry: "'Bevan put his finger on the hospital arrangements devised by Willink as the gravest weakness. And, of course, he was right. They would never have worked. I came away that night with instructions to work out a new plan on the new basis he proposed.'" (12)

The criticism of Willink's scheme was that he had succeeded in appeasing the major interests, but in doing so had imposed a weak regional apparatus with very little effective control over the hospitals, which would retain their powerful governing bodies and local

authority affiliations.

One of Labour's champions of the local authorities, of the London County Council in particular, Herbert Morrison, Leader of the House of Commons and Lord President of the Council, was, as Cabinet records reveal, Bevan's chief opponent of nationalisation of the hospitals.

Arguing before Cabinet, Morrison praised Bevan's scheme as "brilliant and imaginative" but saw "no urgent and strong public need" for nationalisation; it would rather be a major step in the weakening of local government. It would incur wide opposition, among Labour councils and others, which would be unfortunate considering the impending local government elections. He further claimed Labour had no mandate to nationalise the hospitals since no such policy was proposed in "Let Us Face the Future."

Bevan recognised the difficulties but argued, point by point, that they could be overcome in the interest of a more sound hospital scheme. As for a mandate, he noted: "Even though we did not put this present proposal in our manifesto, it accords with its spirit." If the whole scheme were properly presented, with the support of the more forward looking representatives of all the concerned interests, Labour would not lose politically. (13)

The Cabinet held one inconclusive meeting on the hospital proposals, with general sympathy being voiced, and ordered a delay to seek advice on financial implications. By the second meeting, Herbert Morrison had mustered his arguments in opposition, again stressing that the last Labour Conference had given no authority for such a measure. In its second discussion, the Cabinet was closely divided. The Prime Minister's support was crucial in the Cabinet's decision to approve

Bevan's proposal in principle, while maintaining the decision in confidence and sounding out local government opinion, then working out details with a view to attracting local interests. (14)

This then was the government's course of action over the following approximately two months. Official silence was maintained, broken only by press rumours of nationalisation, of which the TUC and the BMA were aware. (15) No policy, however, was revealed by the government until Bevan's announcement in the House of Commons, 6 December, that sale and purchase of general practices would be ended in the new scheme. The Cabinet in late December again held discussions on the non-hospital portions of the NHS. The whole of the proposals, apart from those concerning sale and purchase, were kept officially secret until revealed in confidence in early January 1946, first to the TUC, then to the Negotiating Committee of the Medical Profession.

The Decision to End Sale and Purchase of "Goodwill," December 1945

Bevan's second major policy decision was as decisive as the first, and again was a significant departure from Coalition policy. While the decision, like nationalisation of the hospitals, was made without formal consultation with his political colleagues in the SMA and TUC, it was consistent with 1945 Conference policy. This was the decision to end the sale and purchase of the "goodwill" (i.e., of lists of patients) of general medical practices, and to arrange a system of compensation.

Bevan noted to the Cabinet the particular urgency of setting a policy, considering the large number of armed forces doctors about to be demobilised, and the desire of the medical profession to know the government's intentions. Thus, with only the mild objections of Herbert

Morrison, who would have preferred not to deal with NHS proposals piecemeal, Cabinet decided 3 December 1945 to support Bevan's plan to announce the end of sale and purchase. Bevan accordingly met the Negotiating Committee of the medical profession 4 December--his first formal meeting with them--to give them confidential advance notice of his decision, which was announced in the House of Commons 6 December, in response to a pre-arranged question put by Somerville Hastings. (16)

Bevan also announced in the House of Commons a "Charter for Nurses," drawn up in association with the Ministry of Labour and designed to modernise working conditions for hospital nurses in order to aid recruitment. The traditional, strict, and arbitrary rules of conduct would be liberalised, a ninety-six hour fortnight would be put into effect as soon as possible, and a national joint council was set up to cover domestic nursing and non-nursing staff. (17)

The Decision Against a Fully Salaried Service, December 1945

The SMA, and its members and allies in the Parliamentary Labour Party Health Committee, were now well aware that the overall plan of the health service was taking shape in the Ministry. Shortly after the Commons announcement on sale and purchase, the Committee met to discuss the issue of remuneration of doctors. Somerville Hastings informed Bevan of their unanimous opinion "that the payment of doctors should be exclusively by salary and without capitation"; a deputation was to meet Bevan's Private Secretary to argue the point in person.

Bevan was advised by his senior officials against accepting the idea. Salary, they pointed out, was appropriate only for doctors working regular hours doing specified duties, as in a hospital or

clinic. Its disadvantage, in the opinion of the officials, was in removing a personal relationship between patient and doctor--it would be more appropriate in a wholly state service, separate from any element of private practice. A blend of two systems was therefore suggested: a basic part-salary, plus capitation fees, which could be pooled in health centre practices to remove elements of competition. This was, of course, similar in essence to the proposals in Henry Willink's White Paper, which presumably had also been advocated or suggested by the same senior officials.

The Health Committee of Labour MPs met Bevan 19 December, and were persuaded to accept, as an interim measure, since a full health centre system would take some time to build, payment by part-salary and capitation. Somerville Hastings, in noting to Bevan his acceptance of the compromise, urged the Minister to make a commitment to a fully salaried service when the health centres came into use; only this way could destructive competition be eliminated, and the "disease service" be turned into a preventively-oriented health service. Equally, the distinctions between specialists and practitioners might be lessened productively if both were paid on the same basis. Bevan, in reply, admitted Hastings might ultimately be right, but he was obliged to seek ways of minimising competition which would be acceptable to the medical profession; the compromise, he felt, should in large measure satisfy both ends. (18)

Cabinet Approves the Overall Organisation of the NHS, December 1945

The hospital service, sale and purchase, and remuneration issues thus settled, Bevan, in mid December, put his general proposals for the

National Health Service as a whole to the Cabinet. The new service would consist of a tripartite structure:

1. A national hospital and consultant service in Regions, under the Minister
2. Domicillary and clinic services to remain the primary responsibility of major local government units, in turn responsible to the Minister
3. Family practitioner and dental services, under new local Executive Committees for each county or county borough area, with public, professional, and local authority representation, acting under national regulations.

Equitable distribution of practitioners would be the task of a special, mainly professional advisory body; a Central Health Services Council and special representative Standing Advisory Committees would provide expert advice on various general and professional matters. Teaching hospitals would enjoy special provisions: retention of their Boards of Governors and the right to accept and maintain endowments; and a separate annual budget provided directly by the Minister, with full discretion in expenditure. As for the remainder of the hospital service, the plan adopted by the Cabinet in October would stand.

The general practitioner service would be administered by local Executive Committees, within major local authority boundaries; the representative composition of these bodies was also suggested. Significantly, the development of the health centre system was considered "a principal objective from the outset," with publicly provided, staffed and equipped centres, under the local authorities, to be set up "as fast and as widely as possible." Practitioners would be encouraged to join the service and to group together in centres, from their existing locations, with the aim of assuring a family doctor for everyone, either in a health centre or not. Health centre services

could be co-ordinated with both the hospital specialist service, and the local authority clinic and welfare services. Medical staffs of health centres, and solo practitioners, would be hired by the local Executive Committees.

Remuneration of practitioners, as previously decided, would be by basic salary, plus capitation, which doctors in health centres would be encouraged to pool. Remuneration rates for all doctors and dentists would be set nationally. Dentists, until a dental service could be established in health centres, would be paid by fee for item of service. A Central Committee on the Distribution of Practices would work with the Executive Committees to ensure a reasonable distribution of medical practices.

Drugs and pharmacy services would be included in the scheme, contracted for by the Executive Committees. These Committees would also approve opticians and ophthalmologists for inclusion in the NHS, paying them fees for services rendered. In addition, a blood transfusion service and public health laboratories would be included.

A major concession to the specialists and consultants who would join the public hospital service was the provision for "pay beds," in separate parts of some hospitals, to enable them to treat private patients in hospitals in which their part-public practices were located. This was designed, according to Bevan, "to prevent the national hospital service driving all private work into a rival nursing home service and to encourage the fuller association of the specialists with their hospitals in all their professional activities." The "pay beds" should not encroach on necessary public hospital accommodation, and medical fees charged by specialists to private patients occupying them would be

within controlled limits, in addition to the fees charged by the hospitals to patients for use of the beds.

Bevan noted to the Cabinet that his proposals concerned only the general treatment services; a review would also be needed of environmental and local government health provisions, in addition to a vigorous policy of health education.

The matter which most concerned the TUC, and on which the BMA was agreed, industrial health, Bevan admitted was left "untouched, for the present" in his plan. He hoped to add, in the next session of Parliament, measures to come under local government for the care of children, the aged, blind, and the permanently disabled.

Bevan asked the Cabinet for approval in principle of the NHS proposals, so that parliamentary counsel could begin drafting the Bill for introduction in February. He would at the same time negotiate with the concerned interests, but only "on the basis that all the main features of the proposals must stand and that any concessions made should be such as could be put into effect in administration."

In response to Herbert Morrison, who voiced again his concerns that the nationalisation of hospitals would arouse a great deal of opposition, Bevan noted the support which would be forthcoming from many doctors, thus lessening the general antagonism. Some local authorities would also approve, as would the great majority of government supporters, in Parliament and in the country.

He noted the compromise on doctors' remuneration. It should, he remarked to Cabinet, in a statement which would have been heartening to the SMA and inflammatory to the BMA, "eliminate the worst features of the capitation rate system and lead eventually to a full-time salaried

service." He acknowledged the strong pressure from the Health Group of Labour MPs for a full-time salaried service, and noted that he had finally been able to persuade them to compromise.

With the exceptions of Herbert Morrison and J. Chuter Ede, the Home Secretary, both of whom had doubts about the hospital scheme, the entire Cabinet approved, and authorised Bevan to submit an outline of the proposed legislation, and proceed with detailed drafting and negotiations. (19)

Bevan clarified his position on several issues as the Cabinet discussed the outline of the NHS Bill in early January 1946. He would enter discussions with the interests concerned on the basis of the main principles, on which there could be no concessions; there would be scope for adjustment on details such as the composition of governing bodies, "or the extent to which general practitioners should be allowed to take private patients." It was important, he said, to attract both doctors and the overwhelming majority of the community at large to the new service; in order to do this, "it was important to ensure that the continuance of private practice should not prejudice the success of the national scheme." He again emphasised health centres as the best means of attracting doctors and patients and of revolutionising general practice. He further noted his plans to have the trade unions represented on Regional Hospital Boards. With respect to industrial medical services, however, it was clear that his intentions were not changed; even the existing services, such as in coal mining, would not be integrated, but it was hoped there would be close liaison between the Ministry of Health and other Departments responsible for medical services. With little discussion on other matters relating to the NHS,

the Cabinet then approved the Minister's summary report of the Bill and authorised its preparation in detail.

The Bill was approved by Cabinet in early March, and was given First Reading in the House of Commons 19 March. During January and February, Bevan held initial discussions with the major interests, to relate to them the main proposals, confidentially, in a non-negotiable form, in order to make some assessment of the political reception the plan was likely to receive, and to prepare modifications to ensure the more ready acceptability of the NHS. He was also under continued pressure from the Parliamentary Labour Party Health Group, who were opposed to "pay beds" and to part-private general practice. (20)

The First Announcement of NHS Policy, January 1946

Bevan chose to release the NHS proposals first to a deputation of thirty-six, representing the General Council of the TUC and member unions in the health services, on 8 January 1946, the day the Cabinet gave its approval. The government's mandate, he said, was to provide a comprehensive service, for all, free of charge, the major part of the cost to be borne by the Exchequer, and the rest locally with central assistance. The 1944 White Paper had contained too many compromises with the existing situation, which would have led to excessive administrative complications. Bevan revealed the government's decision to "organise the hospital system on a national basis," under Regional Boards, on which he promised trade union representation.

The government had decided against a fully-salaried practitioner service: "This would be too abrupt a break with the existing system, and took too little account of the principle of payment by results."

The distribution of doctors, he said, would be controlled by negative rather than positive direction. There would be no prohibition of private practice, in order to avoid doctors staying out of the service and creating a black market in private practice. Patients would be allowed to choose private treatment, but those on public lists could not be charged a private fee.

With respect to health centres, Bevan noted "the ultimate ideal was [their] establishment . . . in every local health authority area, but the service must necessarily be developed progressively." Part-private general practice would be allowed, but private patients could not be treated in public health centres; basic part-salaries would apply in or out of health centres.

The TUC deputation appeared not entirely prepared for an announcement of such significance or decisiveness, especially having last met with the previous Minister in March 1945. In their opening remarks, while still prepared to mount a defense of such basic White Paper concepts as the issues of a "one hundred per cent," comprehensive service, which they had feared were in jeopardy under Willink, they were nonetheless prepared to discuss points of direct relevance to health workers and professionals including representation of nurses and miscellaneous grades of workers. Representation of nurses, they argued, "should not be less than [that] of the medical profession," and miscellaneous grades should be represented on any committee of organised health workers. Concern with the future of health centres was shown in the request that they be built and staffed to the highest standards, and set up wherever there was public demand. The TUC agreed that sale and purchase of practices should end, and reiterated the Labour Party-TUC

position in favour of salaried medical practice; at the least, payment by full salary should be a matter of option for each doctor. (21)

The largest disappointment to the TUC was that there would be no major initiative in industrial medicine. Reforms could be made, said Bevan, but (repeating Willink's earlier position) he advised that: "reorganisation could not be effected immediately, since the working out of the necessary changes would take time, and it would delay the main scheme to await the result. Everything would be done from the outset to ensure close co-ordination both centrally and locally, between the industrial and the general health services." (22)

TUC Response to Bevan's Plan, January to June 1946

The TUC deputation took Bevan's sixteen page memorandum on the NHS in confidence, sending copies only to member unions in the health services. The TUC waited until the Parliamentary Committee stage of the Bill, following Second Reading in May 1946, before requesting to send another deputation. In the intervening period, particularly following First Reading of the NHS Bill, they had lobbied Bevan, again unsuccessfully, for the full inclusion of industrial health services.

In considering the NHS Bill, the TUC decided to confer first with the BMA and BHA, to obviate as many differences of viewpoint as possible, before contacting the Minister again. Position papers were accordingly exchanged, the BMA contributing its statement of seven principles regarding the NHS, and the BHA its "Plan for a National Hospital Service." (23)

The next deputation to Bevan, on 17 June, immediately followed the Standing Committee debates and the 1946 Labour Party Conference. The TUC

introduced its several concerns to Bevan, including medical overrepresentation at all levels, and industrial health: "The TUC would never be completely satisfied with the new health service if it did not incorporate industrial health. This was a point on which the BMA were in agreement." They repeated with emphasis their views on health centres, the salary option, adequate nurses' and health workers' representation, and reforms in medical education.

Bevan expressed his thanks for the TUC's support, which "had helped ease the passage of the Bill through the House quite considerably." He requested further help in the detailed discussions which would be necessary to frame the regulations through which the service would evolve. "There was no unalterable contract between the State and the citizens," he said; much was not included in the Bill in order to ensure future flexibility.

On many of the TUC's points of concern, Bevan offered reassurances. This applied to the scope for medical research; limitations on private practice and prohibition of contracting out; and a level of remuneration adequate to ensure a high standard of public service. He explained the government's position on private beds in hospitals as a measure intended to keep specialists within the NHS; the medical needs of public patients would be of first priority. With respect to preventive services, the Minister noted the government's progress with housing, pure water, nutrition, and children's allowances. He was opposed to including preventive services specifically in the Bill. Grants for medical education would aid recruitment from all classes. Private practice, he hoped, would diminish, especially with the success of the public service.

A whole-time salaried service, however, was rejected: "If [it] was insisted on at the present time the vast majority of the medical profession would be mobilised against it. A full-time service was not easy to work in conjunction with free choice of doctor. . . . It still seemed necessary to have some element of reward and punishment. If the same salary was paid for different services, then it would lead to a general slackening in the profession [sic]." The government, Bevan noted, had already made substantial attacks on competitive private practice in the various measures of the Bill, and would encourage pooling of income in health centres; he attached great importance to the development of medicine at the health centre.

A major area of difference appeared between the Minister and the TUC over health workers' representation. The Minister now proposed, rather than minority trade union representation on management committees, that separate staff associations be established. It was, he said, a step toward a "healthy industrial democracy" that workers should participate in the making of policy through their own associations rather than having minority representation on an employing body. In reply to a criticism from a member of the TUC deputation that doctors were represented on all committees throughout the service while nurses had virtually no representation, Bevan replied that doctors were appointed not to give them a special role in administration but "because they were concerned with health in general." He declined also to increase nursing representation on the Central Health Services Council. Again pressed on industrial health services, Bevan repeated his commitment to action only after the commencement of the main service.

After a brief discussion of ancillary services, the TUC spokesmen

thanked Bevan and assured him of the support of the trade unions in the passage of the Bill through the House. (24)

The SMA's Continued Campaign for a Socialist Health Service,
January to July 1946

The Socialist Medical Association, having been reconciled to Bevan's basic salary and capitation fee compromise in early January, also offered its support to him, but in the next several months engaged in some close questioning about several features and implications of the NHS Bill. The SMA's first deputation to Bevan took place 17 January 1946. In addition to explaining his general proposals, Bevan noted, with respect to some SMA policies, that his Nurses' Code would now remain only a series of recommendations, for lack of resources and the powers to make it compulsory, and further that it would be too large a problem for the government to take charge of medical education. On the issue of staff associations, which were now of much concern to the SMA in view of its strong stand on health workers' democratic participation, Bevan noted they would be encouraged, but "they could not properly be put in a position of controlling bodies." The deputation was also concerned about the failure to integrate industrial health, to which Bevan replied as he had to the TUC.

Subsequent to this deputation, Bevan clarified his proposal for a salaried part or whole time specialist service for the hospitals. He would not, as the SMA had erroneously feared, implement fee for item of service remuneration for specialists. He also provided answers to several questions raised on behalf of the SMA by Dr David Stark Murray. These concerned the role of the university teaching hospitals,

arrangements for private treatment in hospitals, and, in Murray's view the vital issue of the difficulty under the tripartite arrangements of the NHS (hospital, general practitioner and local authority branches) to achieve "unity or even co-ordination between the curative and preventive services."

Murray commented: "It was this [latter] point which, in the past, influenced us to insist on a single health authority, and while we appreciate the reasons for devising three separate administrative structures, this question of prevention of disease does still present a great difficulty. I may say that it is one which impresses the lay public almost as much as socialist health workers and I am constantly asked about it at my meetings."

Bevan's reply provided brief details on all three issues. Significantly, he made it clear now that two standards of extra-cost accommodation would be available in hospitals: extra-charge "amenity beds" for public patients, and private "pay beds" for which the full operating costs to the hospital would be charged, in addition to the doctors' private fees. The latter category would be provided only where "reasonable" and would be available to public patients in case of urgent need. Co-ordination of the three branches, he said, would be the final responsibility of the Minister; he anticipated local liaison and overlapping among the branches. All these problems, he felt, could be solved administratively, and by trial and error in practice. Bevan declined to reply to Murray's request to supply the SMA with the date of publication of the Bill and to give the SMA a copy of it at the same time as sending it to the BMA. (25)

Further inquiries by the SMA followed publication of the Bill.

These generally received routine replies drafted by Bevan's officers. Somerville Hastings did, however, request in May that Bevan see a deputation from the Association. This was arranged for 22 May, the day following the debate on pay beds in Standing Committee. The SMA presented two proposals which it hoped the Ministry would be able to incorporate directly into NHS planning, in such a way as to further SMA and Labour health policy. The first proposal was to identify underdoctored areas for immediate establishment of health centres, which would be staffed by men and women doctors recently demobilised. They noted that fifteen thousand such medical personnel would be leaving the forces. The second SMA suggestion was to employ these young doctors in industrial health facilities, since private industry was already cutting back on the relatively high level of wartime medical staffing.

Discussion with the SMA deputation on these points was general, the Minister making no commitments apart from agreeing to encourage local authorities and voluntary hospitals, in the interim, to appoint more practitioners and specialists. The Ministry decided to wait at least a month before making any official statement of advice to young doctors with respect to establishing practices. (26) Plans were also being made in the Ministry at that time, as the SMA was assured personally by Bevan, for detailed advice to be given to local authorities on the establishment of health centres, including model building plans, but were not yet ready for distribution. (27)

Pressure was kept up by the SMA while the Bill was being dealt with in Committee. In early June, the SMA Annual General Meeting, in a spirit of critical approval, passed resolutions welcoming the NHS Bill but again recommending, rather than the tripartite structure, "a single

administrative body at the regional level, under democratic control, responsible for all the services of the region," and that "provision be made in the Bill to enable doctors, if they so choose, to be paid by salary." They again strongly urged that industrial health be integrated. The meeting resolved finally that the role of the SMA must now change "to support of the scheme through the legislative stages, proposing improvements and regulations; to ensure that conditions of service are satisfactory to health workers and encourage teamwork; to explain advantages of the Service via the Labour Movement and especially to the medical profession so as to encourage their enthusiastic participation."

A few informal contacts were made by the SMA with Ministry officers during the summer of 1946, mainly concerning plans for demobilised doctors. However, there is little or no evidence in Ministry documents that the SMA, through the various legislative stages, did other than provide only general advice; certainly the main framework of the Bill had been constructed by the time of the first SMA deputation in mid-January 1946, and the Minister's official answers (often provided by his staff) to the SMA's inquiries on salaried service, health centres, industrial health, and integrated administration continued to consist of justifications of his earliest policy decisions.

According to Dr Stark Murray, there existed considerable tension between the Minister and the SMA over these issues, which were critical to the SMA's vision of a socialist health service. Particularly on the failure to establish single, elected regional authorities to run the whole service, and on the failure to provide that all employees including doctors be hired on an equal, salaried basis, the SMA felt

Bevan had given way needlessly to the BMA "in order to weaken their general resistance to a one hundred per cent service." The SMA was, of course, extremely happy with the decision to nationalise the hospitals, "Bevan's greatest decision on a disputed point." Once the tripartite system had been designed, and the BMA was relatively satisfied, Bevan was prepared only to defend the structure against the SMA's advocacy of a unified service.

The failure to establish a whole-time salaried service was, for the SMA, "the greatest misjudgement of 1946." It was felt by the SMA that, if the government were to end sale and purchase of practices, with generous compensation, "the point that medicine was being taken out of the market place could have been carried to its logical conclusions." Without it, the old disease orientation of medicine would be more likely to persist, and health advice, education, promotion, and preservation could not so clearly become integral to the purposes of the NHS. (28)

The MPU's Ill-Fated Attempts to Advise Bevan

The MPU attempted to make a similar series of points to those of the SMA with Bevan between September 1945 and January 1946. They were particularly concerned to aid directly in promoting and planning health centres, and recommended several detailed proposals to locate demobilised doctors in the new centres. Despite persistent requests from the MPU to send a deputation, Bevan took the advice of his officers that the MPU should be seen only after his plans were more advanced, and after consulting the BMA. The deputation, which was received in late January, made points consistent with the MPU's health service policy, particularly emphasising that there should be a full-salary option for

doctors in health centres. Bevan replied by restating his own remuneration proposals as the government's firm decisions; he could not comment on unresolved matters, pending official discussions with the medical profession. He promised only to consider MPU representation on the NHS Medical Advisory Committee.

The cordiality of relations between the MPU and Bevan was broken in February and March following an MPU meeting in Swansea at which, the BMA complained to Bevan, the MPU had revealed confidential aspects of Bevan's proposals. The MPU was rebuked by the Ministry, and rebutted that the same points had appeared in the DAILY MIRROR and DAILY WORKER of 7 January, before even the TUC was informed. The MPU continued to hold meetings through March to discuss the proposals, as attitudes hardened within the Ministry against formal representation for it on the NHS Medical Advisory Committee. (29)

The Advocates' Attempts to Modify the Bill in Parliament

The Cabinet, having approved Bevan's draft Bill in its entirety, without amendment, decided to give it top priority in the government's legislative schedule. The National Health Service Bill was therefore given First Reading in the House of Commons 19 March 1946 and a White Paper issued simultaneously, explaining the provisions of the Bill. Debate on Second Reading began 10 April and ended 2 May, after bitter attacks by Henry Willink and other opposition Members. The Bill was sent to Standing Committee C, contrary to Winston Churchill's motion that it be dealt with by a Committee of the Whole House. Willink's amendment to deny Second Reading was rejected by 359 to 172 votes. Debate continued in the Standing Committee through May and June. (30)

During the legislative stages of the Bill, the focal point of SMA activity shifted away from formal presentations to the Minister and toward the daily pressures of seeing the Bill through Parliament with as much SMA influence as possible. Eight of the SMA MPs were members of Standing Committee C; they were in daily discussion with the SMA Policy Committee over Parliamentary strategy. They were also in frequent contact with Bevan, both informally and through exchanges in the Committee. The SMA took credit for establishing the principle that whole-time doctors or other health workers might be members of any board or committee, although in practice Bevan appointed very few non-professionals. (31)

In the Second Reading debate and Standing Committee C, several Labour backbenchers were vociferous in defense of SMA policies, but stopped short of insistence that they be fully included in the NHS Bill. Somerville Hastings, while accepting extra-charge amenity beds in the public wards, expressed profound fears that the provision of wholly private beds would lead to two classes of hospital treatment. The same point was made by another Labour Member, Mr Boardman, representing the Lancashire mining constituency of Leigh. Mr Piratin, MP for Mile End, moved an amendment asking that an Industrial Health Service be established within five years, covering research, preventive and diagnostic facilities, regular examinations, treatment, and rehabilitation. Here Bevan again defended his decision to leave such a service out, for reasons of the extra difficulties involved, and the expected evolution of the service toward assimilation of industrial medicine, and assured Mr Piratin that the government would encourage such trends. Regional Boards would have the responsibility of setting

up special research and treatment facilities appropriate to the industrial diseases of the area. Still disappointed, but agreeing to the Minister's request, Mr Piratin withdrew his amendment. (32)

The Issue of Workers' Representation, June 1946 to October 1947

The issue of health workers' representation came to the fore again in June and July, in the form of concerns expressed by COHSE and the TUC to Bevan that representation would not be adequate. Again Bevan defended his view that representation of miscellaneous grades of workers in staff associations would be more effective than the anomalous situation of minority representation on management committees; these views he put to Sir Walter Citrine, General Secretary of the TUC, in July. He noted that representation on the central bodies had been carefully designed for a proper balance of interest, and commented, perhaps presumptuously: ". . . I am sure you will agree that the medical profession, which is concerned with every branch of the new Service, should have a majority of members on the [Central Health Services] Council." He pointed out that any health worker might be appointed in an individual capacity, rather than as a representative, to any of the management bodies, but that staff associations were the more appropriate form of formal representation.

This view of the Minister's was treated with great concern by the TUC, sufficiently so to request urgently that Bevan receive a deputation. Three points were put to the Minister in writing, in September:

1. The TUC did not agree the medical profession should have a majority on the Central Health Services Council

2. Health workers' representation on hospital boards should be made through the TUC under Schedule 3 of the Bill
3. The TUC would disapprove of staff associations but would consider some alternate form of representation for organised workers in hospitals.

It was also pointed out that Bevan's more recent statements that trade unions would not be represented on Regional Hospital Boards were in conflict with his commitment to the TUC deputation on 8 January 1946. Bevan's officers, not understanding the reasons for the strong objections of the TUC and of COHSE to staff associations, recommended the Minister meet personally with them. This was arranged for 14 October.

At the meeting, workers' representation at all three levels of administration was reviewed. The TUC put the case that, for the Central Health Services Council, the twenty-one medical members out of the total of forty-one, with only two nurses and one midwife to represent general workers, was an example of extremely disproportionate representation. Bevan again defended the proportions, on the grounds that doctors had an interest in every aspect of the service. He did however offer, if the TUC wished, to establish a Standing Advisory Committee for miscellaneous workers. This committee, would advise the Minister directly. The TUC agreed to consider this proposal. With respect to Regional Hospital Boards, it was the Minister's intention to consult the TUC for nominees, to be appointed by the Minister; he would not consult the member unions, or take nominees formally as representatives, but would appoint them as individuals. The TUC agreed to this procedure.

Finally, with respect to local representation, Bevan expressed regret at having previously used the politically loaded term "staff association," which to the trade unions meant an association convened by

the employer and antithetical to trade union organisation. Bevan had in mind local, hospital-based committees of workers, democratically chosen, who would meet management on the day to day issues of running the service. He could not guarantee that only organised (i.e., trade union) workers would be chosen, since there were many grades of employees concerned, both organised and unorganised. He did agree with the TUC that an important objective would be to circumvent the traditional power exercised over nursing and other staff by matrons and superintendents. Bevan suggested that it would be up to the unions to organise freely in the hospitals, and to seek to have union members elected to the staff committees. Bargaining for wages and working conditions would not be a matter for the local committees, thus they should pose no threat to this vital function of unions. Bevan repeated his contention that it would not be good industrial democracy to have a few representatives of workers on management committees. Rather the staff committees would be in constant consultation with management to ensure the voice of the workers would be heard. With respect to guaranteeing freedom from management intimidation in organising, and other matters, Bevan offered to have future talks with the TUC when the management committees were being formed. The TUC deputation closed the meeting noting they were considerably reassured. (33)

This then was the first occasion on which the Minister had effectively consulted with representatives of health service workers; in this case the consultation concerned the not unimportant issue of workers' rights to representation in the running of the service. Decisions on more substantive areas such as the scope of the NHS, particularly the exclusion of industrial health services, were taken

without such effective consultation, with either the TUC or the other trade union and socialist proponent groups.

Further action on the matter of representation was not undertaken until June 1947 when the TUC's Joint Social Insurance Committee met with Ministry officials and gave a firm recommendation that a Standing Advisory Committee for miscellaneous grades of health workers be established, and offered to submit detailed suggestions for its functions. In August 1947, TUC and Ministry officials met to begin discussions on national collective bargaining machinery for health service trade unions; the discussions would be continued following the TUC's Annual Congress at Southport.

By October 1947 the Ministry had issued a draft constitution for a National Whitley Council, and a conference of trade unions concerned had been called by the TUC. The Ministry was also suggesting in circulars to the already-formed Regional Hospital Boards that they consult with local Trades Councils Federations in the appointment of the Hospital Management Committees. (34)

The Proponents' Campaign Continues in 1947: Three Major Issues

The NHS Bill passed all House of Commons stages in July, 1946, and went on to the House of Lords, where it was debated in October. The Commons then rejected the Lords amendment to ensure payment by capitation alone, and on 6 November 1946 the Bill was given Royal Assent.

As far as the SMA and the other proponents were concerned, however, several of their policies still remained on the Minister's agenda for attention, and inclusion in the NHS. The SMA, MPU and TUC were

committed to continue agitation for health centres and for an industrial health service (supported on the latter issue by the BMA), and were backed by various individual trade unions and other organisations. The SMA and the TUC were further committed to encouraging democratic representation of health workers of all grades on management committees, and in health workers' councils. MEDICINE TODAY AND TOMORROW continued to suggest the Minister had made unnecessary concessions to the BMA, whose leadership, the SMA felt, had very little following in the profession as a whole, and criticised the delay in the inauguration of the NHS, projected for April 1948 -- "the sort of date which a different type of government would have fixed." (35) Thus, from a position of critical support for the NHS as a whole, workers' representation, industrial health, and health centres were to be the three major issues pursued by the proponent organisations in 1947.

An Industrial Health Service Postponed

Within the government, the question of industrial health services was effectively turned over to the Ministry of Labour by the end of 1946. Ministry of Health and Cabinet papers indicate nothing of the reasons for this apparent shift of responsibility. In January 1947 the TUC began preparation of evidence to submit to the new Industrial Health Advisory Committee established under the Ministry of Labour to look into the general questions of factory and industrial medicine. In its quarterly publication WHAT THE TUC IS DOING, the TUC announced it had recommended a curative and preventive industrial health service closely integrated with the NHS. What modest optimism remained about the establishment of such a service was to suffer a further blow much later,

in October 1948, when the government announced its decision to defer any action. (36)

Health Centres: The SMA's Final Attempt

Optimism about the health centre building programme also received a setback, apparently due to the serious difficulties in the rebuilding of war-damaged houses. Bevan had sponsored a housing finance Bill at about the same time as the NHS Bill, and had taken an active interest in public housing design, insisting on higher standards of space and amenities in new housing. Scarcity of labour and materials, however, meant that Bevan's goal of 750,000 new units per year, already inadequate in the face of enormous and growing housing demand, was almost impossible to attain. His high standards, and his insistence on a large-scale programme of repairing damaged dwellings further hindered attainment of the targets. The financial disaster surrounding the convertibility of sterling, according to the Anglo-American accord of July 1947, was behind a series of stringent austerity measures taken by the Cabinet in the autumn. In July, when the possibility was raised of cuts in the housing programme, Bevan resisted; he was soon obliged to concede or resign, and his resignation at that time, according to Foot, would have jeopardised the entire government. (37)

Even by early 1947 there were signs that a major building programme of new health centres would be impossible. The SMA, however, was determined to see the centres established. Thus, at the May 1947 Annual Conference of the Labour Party, Dr D. Stark Murray introduced a resolution recognising difficulties in the building programme, but urging:

1. The rapid provision of health centres in all areas by the adaptation of existing large houses or by the use of temporary buildings
2. The inclusion of plans and sites for health centres in all new towns and building sites
3. The building of comprehensive but experimental health centres in several large areas of population.

Murray chose to introduce the resolution on health centres, on behalf of the SMA, ". . . because we believe that the health centres will become the symbol to the whole people . . . of what a Socialist Medical Service really means . . ., [and] what we Socialists really mean by health and by the happiness of the people." He noted that, since health centres were to be a local government matter, they would directly concern many of the Labour Conference delegates.

While supported in debate by others from the SMA, he was not supported by the Minister. Bevan suggested the resolution was too detailed to be appropriate for the conference, and that it would be better to wait for purpose-built health centres. He asked, therefore, that Dr Murray withdraw the resolution, and continue to take up the matter informally with the party executive, with which Murray, for the SMA, complied. (38)

This action of Bevan's may be explained in part by the political isolation he was experiencing, according to Foot, within the Cabinet, and from his former colleagues of the Labour Left. On the basis of Ernest Bevin's foreign policy, with which the Left were in near total disagreement, and the looming financial crisis, a number of backbenchers had formed a "Keep Left" group, publishing a pamphlet by the same name a month before the 1947 Labour Conference. But between this group and the left-wing Ministers, including Bevan, there was no liaison. According to

Foot, "Bevan was even more isolated; he scrupulously refused to discuss Cabinet matters even with his most intimate friends." The isolation of the backbench Left (including the SMA MPs) from the Cabinet made them easy prey for attack from Ernest Bevin and the right wing of the Party. Aneurin Bevan remained, according to Foot, the "hero of the rank and file" in no small part due to attacks by Churchill, and was accordingly re-elected at the top of the list to the National Executive.

But there were stirrings of opposition to his apparent lack of compliance with Party policy. While the SMA did withdraw the health centres resolution, the Conference itself rejected Bevan's pleas not to pass a resolution demanding immediate steps by the government to abolish tied farm cottages. In the face of financial and other domestic and foreign affairs crises, the Government was weak and stumbling. (39) This was, in mid-1947, only the prelude to the measures of economic stringency imposed by Chancellor Hugh Dalton by the end of the year. (40) It began to be clear that the effects on the health centre programme in 1948, despite Bevan's attempts in Cabinet to defend it, while maintaining silence publicly, would be worse even than the SMA feared in 1947.

Health Workers' Representation Planned with the TUC

The remaining major issue of concern to the NHS proponents in 1947 was the representation of health service workers in the running of the service and in collective bargaining.

In October TRIBUNE noted Hospital Management Committees were soon to be appointed and suggested to local trades councils to submit nominations to avoid domination by the old voluntary hospitals

interests. By December, TRIBUNE found many of the new Management Committees already controlled by doctors; this, it concluded, should hasten the organisation of health workers.

In September the Report of the Working Party on the Recruitment and Training of Nurses was issued. The Report was critically reviewed in TRIBUNE by Dr Stark Murray who found it unenthusiastic for change in the traditionally low-status job of nursing, paying scant attention to democratising hospitals, and making no mention at all of the right of nurses to organise in trade unions or through representative councils. He noted that the Minority Report, written by Dr John Cohen, was not published, and recommended that the government make no formulation of long term policy until the Minority Report had been released and studied by the Labour movement. (41)

The Ministry and the Proponents, 1945-1947

The determination of the basic structural features of the NHS, therefore, took place in the relative isolation of the Ministry of Health in the brief period from October to December 1945. In the period immediately after his appointment as Minister, Bevan had made himself thoroughly acquainted with the positions of the major interests, and was well aware of the positions of the proponent groups as a result of their communications to him. His only meetings with any of the groups, prior to his general announcement of policy in January 1946, were to impart information. His meetings from January to March were to outline the government's positions, as decided by Cabinet, and to receive opinions -- not to negotiate.

In late 1945, Bevan had chosen a "model" scheme, taking into

account the positions of the medical profession, the voluntary hospitals, the local authorities, and the proponents. This scheme was, in effect, a hybrid scheme. It was certainly not a wholesale adoption of Labour Party health policy, although several features -- universality, comprehensiveness, funding from taxes rather than insurance -- were comparable with those of the Labour Party and of the Willink plan. The original plan, developed with the involvement and consensus of all the main proponent groups for the Central Committee on Reconstruction Problems of the Labour Party, and the National Council of Labour, had been oriented not only to these "common denominator" principles of accessibility to existing services, but to the prior principles of integration of services, preventive orientation, and full public responsibility of the scheme, combined with democratic representation of all levels of health workers. Subsidiary features of the advocates' model -- full public ownership, fully salaried remuneration, health centres, and occupational health services -- were practical aspects intended to further the prior principles. In reconciling the claim and positions of the major interests with those of the proponents while constructing his general proposals, Bevan was obliged to pay relatively less attention to the prior principles embraced by the proponents, and indeed by the Labour Party, and relatively more to the practical questions of satisfying the major interests. This did not mean the claims and principles of the proponents were ignored; even the principles upon which the Willink plan was based went further toward universality than Beveridge's, for example. But the proponents were arguing for substantial innovations on the one hand, and on the other, unlike the major interests, they were

not arguing from a position of equal institutional power within the existing services.

The distinction, in Bevan's dealings, between the major interests which had a great deal of institutional power, and the proponents, which had little if any (but much popular support), is not perhaps as apparent at the stage of general policy determination, in late 1945, as at the later stages of negotiating the further demands of the major interests and of the proponents in 1946 and 1947.

Whether out of political courtesy or for other reasons Bevan made his general proposals known first to a TUC deputation, representing a variety of health workers' unions. But the substantive demands of the unions, for wide representation of workers in the service and for an occupational health service, were not favourably received. Indeed, while Bevan dealt formally with the Negotiating Committee of the medical profession, settling terms of service by agreement (albeit through a stormy period of disagreement), the relationship with the TUC was considerably less formalised, and its demands treated by the Ministry as essentially not negotiable. In the end, when the central advisory machinery was established in 1947, the TUC was obliged to accept considerably less representation than it and its member unions desired, health centres assumed decreasing importance despite TUC protests, and the issue of industrial health services was treated as entirely closed.

Attempts by the SMA and MPU to establish themselves in the role of permanent advisors to Bevan, in executing Labour Party health policy, were rejected by Bevan, with the advice of his Ministry officials. The proponent groups were treated at arm's length, even though their views were heard. Their attempts to offer advice most directly to Bevan,

through the Parliamentary Labour Party Health Group, were treated similarly. Members of the Health Group were expected to defend Bevan's proposals in Parliament, as the proponent group were in public, while their attempts to enrich the service with advice based on the Labour Party's policy were largely rejected, in deputations, in the Standing Committee, and at the Labour Party Conference.

The role of the proponents had now become the difficult double one of attempting to advocate to Bevan basic features of their model, and of defending Bevan's compromises. In the period of his negotiations with the major interests, and both before and after the implementation of the NHS, all the proponents were to continue their campaign, both of advocacy and defense.

CHAPTER 8 - FOOTNOTES

1. Murray, p. 73.
2. Michael Foot, ANEURIN BEVAN, Volume II, 1945 to 1960 (London: Paladin, 1975), p. 18.
3. Foot, Vol. II, p. 104; see also PRO, CAB 129/1, C.P. (45) 118, "Ministerial Responsibilities for Housing," Note by the Prime Minister, 16 August 1945, for a discussion of Attlee's reasons for leaving housing with the Ministry of Health, with a Ministerial Committee to assist.
4. Murray, p. 74, lists the twelve SMA MPs.
5. PRO, MH 77/63, Correspondence between the SMA and Bevan, 9 August 1945 to 10 December 1945.
6. PRO, MH 77/64, Correspondence between the MPU and Bevan, 12 September 1945 to 23 January 1946.
7. PRO, MH 77/73, Memorandum dated 2 August 1945, sent by TUC to Bevan, 13 August 1945.
8. PRO, MH 77/43, MH 77/45, Correspondence and resolutions from various trade union bodies to Bevan, August-September 1945; MH 77/41, Correspondence between Communist Party of Great Britain and Ministry 25 October 1945 to 11 January 1946, and related Ministry memoranda.
9. PRO, MH 77/43, Correspondence between Labour Health Workers Group of MPs and Bevan, August 1945.
10. MEDICINE TODAY AND TOMORROW, 5 (September quarter 1945), pp. 6-12; THE TIMES, 6 September 1945, p. 2.
11. PRO, CAB 129/3, C.P. (45) 205, "National Health Service--The Future of the Hospital Services," Memorandum to Cabinet by the Minister of Health, 5 October 1945.
12. Sir John Hawton, interviewed and quoted by Michael Foot, in BEVAN, Vol. II, p. 130.
13. PRO, CAB 129/3, C.P. (45) 227, "National Health Service--The Future of the Hospital Services," Memorandum by the Lord President of the Council, 12 October 1945; C.P. (45) 231, "National Health Service--The Hospital Services," Memorandum by the Minister of Health, 16 October 1945.

14. PRO, CAB 128/1, Cabinet Conclusions: (45) 40th Conclusions, 11 October 1945; (45) 43rd Conclusions, 18 October 1945; PRO, Treasury Papers, T161/1243, Papers Leading up to the NHS Bill; see also Foot, Vol. II, pp. 131-133, for a discussion of the opposition to nationalisation in the Cabinet and London County Council, which Bevan successfully overcame.
15. TUC, Joint Social Insurance Committee, Minutes of meetings 15 November and 13 December 1945; Eckstein, p. 159.
16. PRO, War Cabinet Social Service Committee, S.S. (45) 12th Meeting, 29 November 1945, approved Bevan's Paper C.P. (45) 298 proposing an immediate announcement of the end of sale and purchase; CAB 128/2, Minutes of Cabinet Meeting, C.M. (45) 58th Conclusions, 3 December 1945.
17. Foot, Vol. II, pp. 128-129, n. 11.
18. PRO, MH 77/85, Correspondence between Health Committee of the Parliamentary Labour Party and Bevan, and Ministry memoranda, 13 December 1945 to 14 January 1946; Bevan's part-salary position had been ratified on 17 December by the War Cabinet Social Services Committee, S.S. (45) 15th Meeting.
19. PRO, CAB 129/5, C.P. (45) 339, "Proposals for a National Health Service," Memorandum by the Minister of Health, 13 December 1945; CAB 128/2, C.M. (45) 65th Conclusions, Minutes of Cabinet Meeting, 20 December 1945.
20. PRO, CAB 128/5, C.M. 3 (46), Minutes of Cabinet Meeting, 8 January 1946; and CAB 129/6, C.P. (46) 3, "Heads of Proposed NHS Bill," Memorandum by Minister of Health, 3 January 1946; War Cabinet Social Services Committee, S.S. (46) 4th Meeting, 4 March 1946. At this meeting Bevan again noted the opposition of the P.L.P. Health Group to his concessions to private practice.
21. TUC, Social Insurance Committee files, "Health Service: 1938-1946," Internal Memorandum for Deputation to Minister of Health, 8 January 1946. The TUC Deputation represented the MPU; the Transport and General Workers Union (TGWU); the Hospital and Welfare Services Union; the National Amalgamated Union of Shop Assistants, Warehousemen and Clerks; the Amalgamated Union of Building Trades Workers; the Women Public Health Officers Association; the National Union of Printing, Bookbinding, and Paper Workers; and all members of the TUC Joint Social Insurance and Workmen's Compensation and Factories Committees.
22. PRO, MH 77/73, N.H.S. (46) 2, Report of TUC Deputation to Minister of Health, 8 January 1946, and "Proposals for a National Health Service," 16 pp., n.d.; TUC, Social Insurance Committee files, Memoranda relating to Deputation to Minister, 8 January 1946.
23. TUC, Social Insurance Committee files, Memoranda and

correspondence, January to April 1946.

24. PRO, MH 77/73, Memoranda related to TUC Deputation 17 June 1946. TUC, Joint Social Insurance Committee files, Report of TUC Deputation to Minister of Health, 17 June 1946.
25. PRO, MH 77/86, Correspondence between Dr D. Stark Murray and Bevan, February 1946.
26. PRO, MH 77/63, Memoranda relating to SMA Deputation, 22 May 1946.
27. PRO, MH 77/51, Letter from Bevan to the SMA, 30 April 1946.
28. PRO, MH 77/63, Resolutions of SMA Annual General Meeting, 4 June 1946. PRO, MH 77/50 to 55, General Correspondence on the NHS Bill, April to September 1946. Murray, pp. 80-81.
29. PRO, MH 77/64, Report of MPU Deputation to the Minister, 23 January 1946; and Correspondence with MPU, February to March 1946.
30. PRO, CAB 129/7, C.P. (46) 86, "National Health Service," Memorandum by Minister of Health, 1 March 1946; C.P. (46) 89, "NHS in Scotland," Memorandum by the Secretary of State for Scotland, 1 March 1946; CAB 128/5, C.M. 22 (46), Minutes of Cabinet Meeting, 8 March 1946. White Paper in a National Health Service, Cmd. 6761, March 1946. See Lindsey, pp. 43-44, and Foot, Vol. II, pp. 144-147, for accounts of this debate, and 422 HC Deb., cols. 46-408, for the entire debate.
31. Murray, pp. 77-83; MEDICINE TODAY AND TOMORROW, 5 (March quarter 1946).
32. 422 H.C. Deb. cols. 274 ff. House of Commons, Standing Committee C, 19th Day's Proceedings, 2 July 1946, cols. 924 ff.; see also the debate on Health Centres, Standing Committee C, 12th Day's Proceedings, 6 June 1946, cols. 509-525; and Foot, Vol. II, pp. 144-147, 151-155.
33. PRO, MH 77/73, Report of Deputation from TUC to the Minister of Health, 14 October 1946; TUC, Joint Social Insurance Committee Minutes, G.C. 18/14, 17 October 1946.
34. PRO, MH 77/73. Report of Meeting of TUC and Ministry Officials, 25 August 1947; TUC, Joint Social Insurance Committee Minutes, 8 May, 10 July, 9 October 1947.
35. MEDICINE TODAY AND TOMORROW, 5 (September quarter 1946); 5 (December quarter 1946).
36. WHAT THE TUC IS DOING, May 1947.
37. See Foot, Vol. II, chap. 2, "Minister of Housing 1945-1947."

38. Labour Party, Annual Report, 1947, pp. 196 ff.
39. Foot, Vol. II, p. 89.
40. See Hugh Dalton, HIGH TIDE AND AFTER: MEMOIRS 1945-1960 (London: Frederick Muller Limited, 1962), chaps. 25-33.
41. "Wasting Our Nurses," D. Stark Murray, TRIBUNE, 26 September 1947; "Hospital Service Develops," TRIBUNE, 31 October 1947; "Bevan and the Doctors," TRIBUNE, 12 December 1947.

CHAPTER 9

THE GOVERNMENT--1945 to 1949:

CONTINUITY AND CHANGE IN THE FINAL STAGES OF

ESTABLISHING THE NHS

Bevan Meets the Medical Profession

Bevan's first contacts with the medical profession were informal--a dinner speech and a luncheon with the BMA Council--but, according to Foot, he disarmed his erstwhile adversaries with his sophisticated grasp of health service issues, his modesty and eagerness to learn. He learned quickly, particularly about the internal politics and divisions of the profession as well as about medical skills and duties. (1)

While these initial informal overtures to the profession were taking place, Bevan and his officials had drafted the first proposals for the health service, in particular Bevan's most significant alteration to the Willink plans, the nationalisation of all the hospitals. This proposal was discussed and approved by Cabinet in October 1945. That the Cabinet was considering dramatic departures from the Coalition plans became the subject of rumours in the press, including rumours of nationalisation of hospitals and the end of sale and purchase, prompting Dr Charles Hill, on behalf of the Negotiating Committee, to request to Bevan in November that substantive discussions

begin. Bevan, replying on 13 November, recognised the profession's concerns with the wider issues of health care, not just with terms of service, and suggested the discussions be to the point: "Neither of us, I think, contemplates beginning afresh a long series of protracted negotiations. Indeed to do so would mean covering all over again ground which has been repeatedly tilled and so wasting time which we cannot now afford." Bevan noted he had no intention of introducing a Bill before hearing the views of the profession. (2)

Their first formal discussions took place on 4 December 1945. Bevan's purpose was to announce to the profession's representatives his decision, which was to be made public in two days in the House of Commons, to end the sale and purchase of medical practices, and to offer compensation. All relevant details would be discussed in full with the profession, as would his larger schematic proposals for a National Health Service, which would be ready early in the New Year. He wished to have the legislation ready to introduce in February, hence there would be no time for protracted negotiations.

The Negotiating Committee of the BMA met following the discussion with Bevan, and decided to oppose any proposal that would involve government appointment and direction of doctors to vacancies or any loss of doctors' freedom to choose a location in which to practise. With respect to sale and purchase, it was agreed that "a practice is a personal asset and the profession should not accept without protest the principle of the destruction of goodwill by the payment of compensation." Their final attitude, they decided, would depend on the precise nature and value of the compensation proposals. Through December and early January the compensation sub-committee of the Negotiating

Committee met several times with Ministry officials and agreed (hypothetically, for the profession) on details of the compensation plan. (3)

In December, the profession published its "Seven Principles," drawn up against the background of press rumours of nationalisation, direction of doctors to practices and full development of health centres, as the government's intentions. The seven cardinal principles were:

1. No full-time salaried service for general practitioners
2. Freedom to practise without state interference
3. Freedom of choice by doctor and patient in general practice
4. Freedom to practise anywhere
5. Right of every practitioner to take part in the service
6. Planned hospital services, based on teaching hospitals
7. Adequate medical representation on the administrative bodies. (4)

These principles were to form the professional, political and ideological terrain on which the Negotiating Committee would do battle with the Minister and Government for the next three years.

On 8 January 1946 Bevan released his general plan for a National Health Service in confidence to a TUC deputation, and on 10 January he released the plan to the Negotiating Committee of the medical profession. The central principles, he said, must stand, but there was "plenty of room for discussion on the methods of working out and applying them." He requested the proposals be discussed only with the executive committees of the bodies represented on the Negotiating Committee--they should otherwise be confidential. (5)

The Initial Response of the Medical Profession, January 1946

The Negotiating Committee held its first full discussion of Bevan's proposals a week later, 17 January 1946. The committee was most favourably impressed with the national hospital service outlined: "It was felt that the transfer of local authority institutions to Ministerial ownership would outweigh the disadvantages arising from the discontinuance of the voluntary hospital system." The special provision for teaching hospitals was fully approved. "The general conclusion of the committee was that, providing the composition and functions of the regional and local executive bodies were satisfactory, the conception of a national hospital service administered through executive regional boards covering natural hospital areas should be approved."

The committee was least satisfied with the tripartite division of the NHS, feeling that without unification of all branches under the regional bodies, "there was no satisfactory method of integration and correlation of what appeared to be three separate services." It was argued that responsibility for health centres should be transferred to the regional boards, with administration by the executive councils as part of the general practitioner service. It was also suggested that practitioners should be much more closely connected with the hospitals. "On the question of health centres, the omission of a period of experimental development [was] a serious defect." The basic part salary method of remuneration was favoured by some members of the committee, and not opposed strongly by the rest, as an efficient method of giving recognition or inducement under certain conditions. The proposals for distribution of practices were not approved by the committee, which would not support even 'negative direction' of doctors. (6)

The Negotiating Committee submitted a formal list of questions for the Minister's reply. While a number of detailed enquiries were made about the intended functions of administrative and staff bodies, perhaps the most substantive area of concern was integration and co-ordination within the tripartite structure of the NHS. The Minister replied that flexibility would be maintained by setting much policy through regulations under the NHS Act, which would be applied by the Minister to all branches of the service. In this way co-ordination could be achieved with respect to major policy matters. Local co-ordination would be undertaken by Ministry officials in consultation with the regional hospital boards, local health authorities, and executive councils, and boards of governors of teaching hospitals, bearing in mind that most of these bodies would have appointees of both the Minister and the professions. The closest local contacts among branches of the service would be encouraged.

In response to the committee's concern with attaining a close association between practitioners and hospitals, the Minister noted the generous representation of practitioners on regional hospital boards and hospital management committees, and added that practitioners would be encouraged to consult with specialists over the care of their patients and to regard the principal hospital of the area as the "natural focus of medical work." (7)

While the compensation subcommittee of the Negotiating Committee continued to meet with Ministry officials to discuss--still hypothetically--terms of compensation following the end of sale and purchase, the full committee also discussed the Minister's proposals and his replies to their questions.

The first formal meeting of the Negotiating Committee with Bevan to discuss his proposals took place 6 February.

Bevan made clear his position on the function of the discussions, particularly with respect to his strong belief in the supremacy of Parliament. The discussions, he said, were consultations rather than negotiations. He would not ask the committee to commit itself or, of course, the profession as a whole, since the government and parliament must bear final responsibility. He would, however, take note of all representations since the substantial support of the profession was his objective. If the main lines of the service were agreed upon, details could be adjusted later.

The committee's reactions on six principal issues were presented bluntly:

1. They were disappointed the service would not be administered by a Ministry having health as its sole responsibility
2. Co-ordination among the branches of the service would not be adequate; practitioner services and health centres, like the hospitals, should be regional
3. They feared the government's proposals "would in time lead to a full, whole-time salaried service"
4. They feared the ownership of health centres by local authorities would in time lead to employment by local authorities of doctors and dentists
5. They feared the proposed machinery for distribution of practices would lead to positive direction of doctors
6. "The Committee reiterated their view that the voice of the doctors themselves should be made predominant at all levels of the new service."

In the meeting, Lord Moran, President of the Royal College of Physicians, supported Bevan's hospital proposals. He was later to play a useful role as mediator between Bevan and the profession. Sir Alfred

Webb-Johnson, President of the Royal College of Surgeons, "pleaded that there should be as little restriction as possible on private accommodation in hospitals" in order not to drive even more private practice out of the health service.

Bevan was certain that there was basic agreement on pay beds. He admitted there was very heavy pressure on him from some of his colleagues to prevent pay beds, indeed to deny any form of private practice in hospitals, but noted he had already committed himself to resisting this pressure and accepting the principle of pay beds, in order to keep the specialists in the hospital service. The final allocation of the beds was an administrative matter and could, with other such matters, be settled later. (8)

The Negotiating Committee issued a ten page memorandum on 8 February 1946 to its constituent bodies. The committee's main arguments, plus its strong support for an industrial health plan, as well as the Minister's positions, were noted, along with the supposition that there would probably be no further consultations with him before the introduction of legislation. (9)

Having made its views known on only a single occasion to the Minister, and in its document to the constituent organisations, the Negotiating Committee, like the BMA and the Royal Colleges, and the other interests, awaited the publication of the NHS Bill in March.

Bevan's Report to Cabinet, March 1946

The Cabinet had approved the heads, or main features, of a draft Bill, along with the exclusion of industrial health services, in early January. The Bill itself was presented in full draft form to the

Cabinet on 1 March and approved a week later. In an accompanying memorandum, Bevan noted the results of his discussions with the medical profession and the interested groups to date. He had held all discussions under conditions of confidentiality, seeing the various organisations' representatives in their personal capacity as experts, not as delegates. He expected there would be vocal opposition from the medical profession at first, but that the responsible leaders and members "are broadly reassured that the proposals . . . represent a reasonable and fair solution to the problems involved." The voluntary hospitals' representatives, he said, were hostile and would certainly organise opposition; again, however, the responsible leaders would accept the proposals as reasonable. He expected the leadership of the London County Council, which was in favour of the proposals, to prevail over the County Councils Association and the Association of Municipal Corporations, both of which were opposed.

Bevan noted the Cabinet's approval in principle of pay beds, and the fact that government supporters would object to this and to the lack of provision for salaried remuneration. Bevan was satisfied that in a salaried system it would not be possible to provide freedom in the choice of doctor. (This, of course, was a point long refuted by the SMA in its preparation of Labour policy, and under the Coalition government, by senior Ministry officials.) The strict controls to be imposed on pay beds should disarm some criticism, he noted, and the method of remuneration to doctors was not set out in the Bill. It would be determined by regulation. This, he said, seemed prudent considering the controversial nature of the issue.

Much of the final shape of the NHS would be left to regulation.

This would ensure future flexibility, would provide a useful role for discussions with the several interests before finalising the service, and would save Parliamentary time. The appointed day to begin the service would be determined by Order in Council, to coincide with the beginning of the new comprehensive national insurance scheme. The separate Bill for Scotland would, at the request of the Secretary of State, be introduced later, when the Bill for England and Wales had had its Second Reading.

The Cabinet, having approved Bevan's draft Bill in its entirety, without amendment, decided to give it top priority in the government's legislative schedule. (10)

Concerted Opposition from the Medical Profession Begins

As the debate was taking place in the Commons, the BMA, in early May, held the first special meeting of its Representative Body in its vigorous campaign against the provisions of the Bill. The doctors were in a militant mood--their opposition to the main provisions of the NHS was resolute:

On the first day, by thumping majorities, any mild voice of dissent was silenced, and one by one large holes were knocked in the whole fabric of the scheme. State ownership of hospitals was defeated by 210 votes to 29. Any idea of control over the areas where doctors should practise was defeated by 214 votes to 2. The proposal to combine a basic salary with capitation fees was defeated by 209 votes to 9. (11)

The meeting passed judgement on the Bill as a whole by agreeing that existing medical services needed improvement and co-ordination, but rejecting the methods proposed by the government to achieve those ends. The minority voice of the SMA in the BMA Representative Meeting, and at

large, was ridiculed, according to Foot.

The Negotiating Committee, which had embarked on a reasoned strategy to concentrate on three or four major amendments, was taken by storm by the Representative Body. Any sense of priorities in concessions to be sought vanished as broadsides were launched against the scheme in general and in its particulars, but especially against the Minister. While the personal and political vehemence of the BMA attacks on Bevan and his scheme suited the Conservative opposition, there was little tactical co-ordination between the Tories and the BMA. Indeed some of the positions of the Tory front bench did not at all accord with the views of the BMA -- notably regarding the nationalisation of the hospitals. Conservative spokesmen took the stand of the British Hospitals Association - resolute opposition to takeover. But the BMA leadership had recognised in Bevan's proposal a more viable method of reconstructing the entirety of the hospital system on a sound financial, medical and organisational footing than Willink's plan had provided.

Differences over Hospital Nationalisation -- the BMA and the BHA

A split between the BMA and the BHA over nationalisation occurred as early as 7 February, in a meeting between the Negotiating Committee and the BHA. (12) Lord Moran of the BMA had spoken publicly and in the House of Lords in favour of Bevan's plan to consolidate all hospitals under the Minister. Between February and April, however, as Bevan had anticipated, the BHA and dozens of voluntary hospitals, large and small, joined in a massive publicity campaign to defend the autonomy of the voluntary hospitals against "confiscation."

The day before the First Reading of the Bill, the BHA released its

"Plan for a National Hospital Service." The Secretary of the BHA, Mr J.P. Wetenhall, had earlier reacted vehemently to the revelation by Bevan, in confidence, of his proposal to take over the hospitals. The representatives of the BHA were not at all mollified by Bevan's suggestion that he wished to provide the best footing upon which the voluntary hospitals could carry on their valuable traditions, including that of local, voluntary interest, nor by his commitment that the government, while taking over endowments and trust funds, would do its best to ensure that benefactors' intentions were fulfilled. (13) The BHA's "Plan for a National Hospital Service," a single-page leaflet, proposed a system of central and regional co-ordination in which existing ownership and management functions would be retained. Voluntary hospitals would be supported in the main by contractual payments from the state, much as the Willink plan had proposed.

The King Edward's Hospital Fund for London took a more co-operative approach with the Ministry following Bevan's revelation of his plan. The Fund suggested the compromise that teaching hospitals with large trust funds be allowed to retain them, while others might have their funds disbursed by trustees for each hospital area, according to their original purpose as far as that could be reconciled with the goals of a unified hospital system. The Fund volunteered its own services, and those of the Nuffield Provincial Hospitals Trust, in an advisory capacity.

Bevan had decided on the essence of such a plan by early March, and was duly congratulated by Sir George Aylwen, Treasurer of St Bartholomew's Hospital and Chairman of the Voluntary Hospitals Committee for London, who noted that one half of total trust fund monies were held

by the teaching hospitals. Sir George Aylwen, shortly after publication of the Bill, congratulated Bevan again on its general provisions, noting his differences with many of his colleagues, and complaining only of medical dominance of the new Boards. (14)

While the King Edward's Fund chose to co-operate, the BHA spearheaded a massive protest campaign of voluntary hospitals from March through June 1946. The protests of some fifty hospitals are on record in the Ministry's files, with only one hospital, the Breconshire War Memorial Hospital, expressing approval.

From Cambridge, for example, Addenbrooke's Hospital forwarded a lengthy memorandum arguing against nationalisation, and in favour of co-ordination with substantial local autonomy; otherwise, "the service will become one vast, slow-moving, soul-less state monopoly with no personal touch and no competition to keep it on its toes." Addenbrooke's feared that, in the long run, treatment outside the service would become impossible.

By late May, when the Bill was still in Committee, all major disputes between the King Edward's Fund and the Ministry had been resolved. The Fund accepted nationalisation in principle, and carried on a co-operative working relationship with the Ministry, providing detailed suggestions for the disbursement of Exchequer and endowment funds to the hospitals, accepting Bevan's principle that the endowment monies should be distributed primarily according to need. The Minister by this time had accepted the request of both the BHA and the Fund that local hospital management committees, in addition to regional boards and boards of governors of teaching hospitals, be allowed to accept and hold bequests of money or property to be used according to the wishes of the

testator. (15) This concession by Bevan was the last step in the official reconciliation of the BHA also, which felt that the ability of hospitals to hold bequests would go far to maintain the continued voluntary interest of the public. The BHA therefore sponsored only minor amendments during the Committee stage of the Bill.

BMA Pressure and Bevan's Minor Concessions, May-July 1946

The major contest of the Committee stage was that between the Minister, and the BMA, which had the support of the former Minister, Mr Willink, and other opposition Members. Bevan sought to take a middle road between the BMA, and the SMA and Labour Left, while hoping to retain the support of the public, which was now well-aware of the disputed features of his scheme: "The more violently the BMA protested, the more he could quell Left-wing suspicions that he had already conceded too much and the more he could mobilize support in Parliament and the country. This he believed was essential, for in the subsequent months anxious Morrisonian voices were often raised in the Cabinet."

(16)

The meeting of the BMA Representative Body in early May had set the tone of the opposition attack in the Standing Committee. The issues pursued by the BMA were the very ones which Bevan regarded as fundamental to his scheme and on which he refused to offer major concessions:

1. Abolition of sale and purchase, even though a hypothetical figure of sixty-six million pounds aggregate compensation had already been agreed upon in meetings between the Negotiating Committee and Ministry officials
2. The basic part salary in general practitioner remuneration

3. Final appeal procedure in cases of professional discipline, the doctors demanding a stage of appeal beyond the Minister to the High Court
4. The use of some method of equitable distribution of doctors and medical practices
5. State ownership of the hospitals, the Negotiating Committee now reversing its earlier position to take that of the majority of the BMA meeting -- resolute opposition.

The Negotiating Committee met with the Minister some three times during May to press these issues. At the first meeting, Bevan sought to reassure the committee on several points. He had given the medical profession an extraordinary amount of self-government and administrative power in the scheme, he said, more than any other profession or trade, and felt grieved that this had not been sufficiently recognised. He had reduced the part salary from a large to a very small part of total remuneration in general practice, and now assured the committee, referring to his SMA colleagues, that "whatever disposition there might be in the minds of certain members of the House of Commons for a whole-time salaried service, it was not in the minds of the Ministry." With respect to the distribution of doctors, there were many safeguards against abuse, and the medical profession, through local and central bodies, would have effective power to determine the hiring of doctors. Abolition of sale and purchase of "goodwill" was a central principle and could not be changed. On the other hand, fears expressed regarding threats to the continuance of private practice would prove groundless, despite the criticisms from within the Labour Party of his provisions for private practice in the hospitals. Likewise, while he would consider greater autonomy for the new hospital management committees, state ownership of all hospitals was one of the major principles which must remain.

At the second meeting, on 20 May, Bevan turned down the Negotiating Committee's requests: a) to set aside a certain proportion of private beds in which maximum private medical fee limits would not apply; b) to provide grants-in-aid to patients receiving private treatment in hospital; and c) to retain all existing private hospital blocks. He again reassured the committee that it would be in the best interests of the profession to have disciplinary appeals stop at the level of the Minister rather than making them a matter of court jurisdiction. He also agreed to modify the Bill to allow employment of assistants by general practitioners, and sought the profession's views on the best policy for employment of young demobilised doctors. While the Minister would have compulsory purchase powers at his disposal, it was highly unlikely, he replied to the committee, that they would be used against private specialist clinics.

The Minister stood by his earlier positions, at the third meeting, on 27 May, on regional co-ordination of services, and health centre planning, against the committee's suggestions, voicing BMA policy, that local authority services be brought under the administration of the regional boards, and that all proposals for establishing health centres, by local authorities, be approved first by the Central Health Services Council. Bevan also declined at this point (a matter on which he was to relent in April 1948) to accede to the committee's request to amend the Bill to preclude the establishment of full-time salaried practice by local health authorities. He did, however, agree to introduce, in Committee, a number of amendments which would improve the Bill and allay some of the fears expressed by the medical profession. (17)

BMA and Opposition Pressure Continued, July-December 1946

One position likely to reassure the doctors was Bevan's refusal to include any reference, in legislation (at least at this point), to method and amount of remuneration; this would instead be dealt with by regulation, after further consultation with the profession. Bevan did agree to allocate some portion of endowment funds to the local hospital management committees.

The Negotiating Committee considered their position in mid-July, following the Committee Stage of the Bill, and decided not to meet again until October 1946, deferring consultation with the various medical bodies concerned until after the Bill had become law. (18)

The solidarity of the BMA, meanwhile, was showing some signs of weakness, and a certain polarisation was developing between members wishing to carry on a militant crusade against Bevan and his Health Service Bill, and those who supported in essence its general provisions and were willing to engage in amicable discussions over details. One of the latter, significantly, was the President of the BMA, Mr Henry Souttar, who in early June 1946 withdrew from the BMA Council's active opposition, indicating to the Ministry his support, along with many other eminent doctors, of the main provisions of the scheme. He noted these were arrived at only after extensive and thorough investigations by the experts of the Ministry, the Nuffield Foundation, and others. "I would reiterate that the service which is envisaged is not the mere doctrinaire whim of a Party, but has its foundations firmly laid in years of laborious discussion in which the Association [the BMA] has taken a most honourable share." (19)

The BMA Representative Body, meeting in July, reaffirmed all the

major uncompromising resolutions of its May meeting. Bevan's concessions during the Committee Stage had had little, if any, effect on the attitude of the BMA activists. The meeting voted against further negotiations with the Minister, and in favour of a referendum on the issue of refusal to hold more discussions until such time as Bevan made major concessions. The split between the BMA leadership and the Royal Colleges was by now widening, with conciliatory statements expressed by Sir Alfred Webb-Johnson, President of the Royal College of Surgeons, and in a resolution of the Royal College of Physicians.

During the debate on Third Reading in the House of Commons, held while the BMA Representative Body was meeting, the Conservative opposition moved rejection of the Bill "in terms even fiercer than those employed on the Second Reading." (20) Bevan's counter-attack on the opposition was equally fierce, especially on their own ground -- the defence of private medicine and the private ownership of voluntary hospitals. He defended the Bill as protecting, rather than harming, the security, independence and conditions of practice of the medical profession. The Bill passed Third Reading by 261 votes to 113, the Conservatives maintaining their opposition to the end.

The House of Lords debated the Bill in October, making only one significant alteration, a clause forbidding the payment of a basic salary. This clause was subsequently removed in the Commons. The split in the medical profession continued to be evident in the Lords, however, in the acrimonious debate for and against the Bill between Lords Moran and Horder. Lord Beveridge was among those who recorded their approval. Royal Assent was given to the Bill on 6 November 1946.

Later that month the BMA held its first referendum of members on

the question of whether the Negotiating Committee should continue to meet with the Minister. The vote was 18,972 in favour of holding further discussions and 23,110 against, with 64 per cent of general practitioners opposing, but only 55 per cent of specialists and consultants. Among younger consultants and salaried doctors, the majority were in favour of continued talks. The BMA Council's decision to break off discussions was ratified in another Special Representative Meeting by an overwhelming majority, and the Council informed the Minister it was without mandate to negotiate.

Discussions Continue, February to December 1947;

Bevan Reassures the Profession

On 2 January 1947 the Presidents of the Royal Colleges intervened to avert an impasse by inviting the Minister to make clear his position on the main issues of concern to the profession by indicating policies to be adopted in regulations under the NHS Act, with respect to three areas of contention. Bevan, on 6 January, welcomed the continued advice and participation of the profession, and gave assurances on remuneration of practitioners by capitation payment, on freedom of movement for doctors, and on the scope of medical tribunals. On the basis of these, and the assurance that further amending legislation would not be precluded, negotiations with Bevan resumed 28 February. At the first meeting, Dr Dain commended Bevan not only for declining to implement his party's policy on a salaried service but also for accepting a number of other major points requested by the profession. Bevan replied, noting the pre-eminent position he had given the profession in the scheme despite criticism from his colleagues. The Negotiating Committee

appointed six sub-committees which met with officials of the Ministry through the summer of 1947. (21)

The BMA Council published in early November the results of these sub-committees' meetings with the Ministry representatives, and the Minister met the full Negotiating Committee in early December, for the first time since February. The two-day meeting ranged over the entire list of objections of the Negotiating Committee to the Act, many of which were restated from May 1946. Bevan observed that the profession's points were so thoroughly contrary to the Act that not merely amendments, but a new Act would be necessary to satisfy them. Bevan stood firm. Limitations of NHS general practices in overdoctored areas would remain; this did not, however, mean the positive direction of individual doctors. The abolition of sale and purchase would be carried out, but a medical practices committee would be set up to determine compensation arrangements and procedures for bringing partnerships wholly or partly into the service. The basic part salary had been set at three hundred pounds, and capitation fees of eighteen shillings per patient would be paid by the executive councils. The Minister could not agree to final appeal to the courts, believing it would not be in the interests of the profession.

Bevan reassured the committee that the government did not intend to nationalise profit-making nursing homes under its powers to take over hospitals. He now changed his earlier position and offered to meet one of the committee's demands on private hospital practice, permitting the allocation of a certain proportion of private beds which would have no set maximum limits on medical fees. However, public 'amenity beds', which the profession had opposed on the grounds that they would compete

unduly with private hospital practice, would remain.

On another issue of great concern to the committee, Bevan said he could not guarantee appointment of the profession's nominees directly to administrative bodies. This would be inconsistent with Ministerial responsibility; rather, the system whereby the Minister would choose from a list of potential nominees must stand.

Bevan noted the capitation fee had been set initially at the relatively high rate of eighteen shillings as an incentive to join the service, and in the expectation that approximately ninety-five per cent of the population would join lists as patients of health service doctors in the first two years. If the proportion of the population joining were less, due to the scheme being launched in strife, the government would be obliged to reduce the fees after two years. Bevan noted that he had avoided for two years making any public statements likely to cause discord, that he hoped to avoid future controversy, and his hope that the profession would give the scheme a fair trial, "with the assurance that if it is found wanting in any particular we shall not be tardy in asking Parliament to make the necessary modifications." (22)

The BMA Rejects Bevan's Reassurances, January to March 1948

Following these important meetings a storm was unleashed in medical politics by the leaders of the BMA. The BRITISH MEDICAL JOURNAL, according to Foot, attacked the NHS Act as leading "unmistakably to the establishment of a full-time service," and as threatening the continued existence of the medical profession as a body of free men. On 1 January 1948 a mass meeting of doctors at BMA House was told by Dr Cockshut that the future of medicine was at stake, with the imminent threat of a

"whole-time salaried service under the State." Another Special Representative Meeting of the BMA, on 8 January, planned a plebiscite of doctors on participation in the NHS, and voted unanimously for a resolution stating the Act, in its present form, should be rejected absolutely by all practitioners.

Amid a welter of attacks from BMA leaders and the press, Bevan reaffirmed, in a resolution in the House of Commons 9 February 1948, the government's intention to adhere to the appointed day for the coming into operation of the NHS, 5 July. In the debate, Bevan attacked the BMA leadership for misrepresenting the views of the majority of the profession. He sought the detailed opinions of the opposition on those issues--part salary, abolition of sale and purchase, limited ("negative") direction of doctors, and appeal procedures--with which the BMA took strongest exception. He also noted the concessions made to the medical profession throughout his discussions with them: pay beds for private patients, both with and without imposed limits on fees, and part-private practice for general practitioners. Labour backbenchers had opposed both these concessions as elements of a two-class health service, carrying the dangers of a class distinction in the quality of medical treatment. Despite Bevan's acceptance of a Conservative amendment pledging support in general (and to Bevan innocuous) terms, the Tories voted against his motion welcoming the scheme. The resulting vote was 337 in favour to 178 against. Bevan accordingly directed his Ministry officials to proceed with all planning on the assumption of the NHS coming into effect on 5 July.

Another plebiscite by the BMA at this time recorded the overwhelming opposition of the medical profession to the Act. While

Bevan announced the Act would, nevertheless, come into effect on the appointed day, Dr Cockshut, for the BMA, announced it would not. Amid much more heated argument in the daily press and the medical press, another BMA Special Representative Meeting was held 17 March. The meeting was once again united in welcoming the results of the referendum: of the 84 per cent who responded, 88 per cent declared they would not work under the Act.

Bevan's Major Concession, an Amending Bill, April 1948

By early April, Bevan decided it was he who must take the initiative in breaking the impasse so bitterly maintained by the profession. On 7 April, he announced in the House of Commons several substantive concessions and his willingness to continue discussions. The chief concession was his offer, after sustained BMA pressure, to introduce a statutory provision against a full-time salaried service, and to abandon the basic part salary. Most doctors would be paid by capitation fees only, while young doctors and others needing it would receive a supplementary rather than a basic fixed annual payment, the details of which would be worked out in future discussions.

Bevan would not yield on the issues of sale and purchase, appeal to the courts, and negative direction, apart from promising a special review of the distribution of doctors in two years. On several other issues he gave unqualified reassurances:

There would be complete freedom in clinical matters, as well as freedom of speech and publication . . . Approval of place of practice by the Medical Practices Committee would be automatic except in areas where there was an excess of doctors. Hospital appointments for consultants and specialists would in most cases be part

time. Private doctors would be able to obtain free hospital and specialist benefits for their patients. In selecting medically trained men for membership in administrative and advisory bodies, the Minister of Health would consult with the professional associations. (23)

In the case of the agreement to statutory prohibition of a salaried service, the impasse had been broken by the consultations by Bevan in late March with Lord Moran, Sir Alfred Webb-Johnson, President of the Royal College of Surgeons, and Mr William Gilliatt, President of the Royal College of Obstetricians, aided by a resolution of the Comitia of the Royal College of Physicians urging the Minister to pass such an Amending Act. (24) The role of the Royal Colleges and of several eminent consultants had been crucial in widening the split in the BMA leadership. Bevan made it clear, in announcing his statutory amendments, that this had been the turning point, and that he was fully in accord with the resolution.

After his 7 April announcement in the Commons, Bevan met inconclusively with a small group from the Negotiating Committee on 12 April. With the gulf now opening wider between the Royal Colleges and the BMA leadership, following the successful initiative of the Royal College of Physicians and Bevan's immediate response, the BMA Council met 15 April, "the most crucial Council meeting in the Council's history and, significantly, it is one of the few not reported in the columns of the BRITISH MEDICAL JOURNAL." (25) Amid great confusion in the BMA leadership, it was decided that the changed situation resulting from the Minister's promised Amending Act warranted a new plebiscite on participation in the NHS. The profession was rent with division, from local groups to the BMA Council and Representative Body.

The plebiscite was held in late April; the results, announced on 5

May, showed some easing in medical opposition. A small majority were still against working under the Act, but the majority was more than 3000 short of the figure of 13,000, chosen by the Council as the minimum number opposing, if doctors were to be advised to remain out of the NHS.

By the end of May, the BMA Council, led by its Chairman, Dr Guy Dain, after lengthy agonising, had decided to continue negotiations on the terms of the Amending Bill, and to recommend that doctors should join the service. Despite opposition maintained by the minority faction through June, and at the BMA's Annual Representative Meeting, the profession now swung dramatically behind the Service. By the appointed day for the commencement of the NHS, 5 July 1948, ninety percent of general practitioners, for example, had registered. By now, historic objections of the BMA leadership notwithstanding, GPs had recognised that the maintenance (indeed enhancement) of their livelihoods depended on joining. It was apparent from the rate at which patients were joining -- three quarters of the population by the appointed day growing to ninety-seven per cent by the end of the year -- that doctors must either follow or lead, in order to retain their clientele.

The Amending Act (the promise of which by Bevan in April and May of 1948 brought the cessation of official medical opposition), was introduced in Parliament in May 1949 and became law in December of that year. The Bill itself was based, in its details, upon the recommendations of a joint committee of the Ministry and the medical profession. Its effect was to validate existing partnerships (a departure from the original Act) and to provide that the power of regulations should not be used to introduce full-time salaried general practitioner, hospital specialist, or dental services (except for dental

practises at health centres). It allowed for charges for pharmaceuticals, and for charges for non-residents of Britain receiving services. A number of minor changes were also made. The medical profession, well represented in the drafting of the amendments, was therefore satisfied that it had won a victory, on a major issue of principle. (26) Bevan's decision to prevent the provision of a fully salaried service was, of course, diametrically opposed to the position of the proponents who had maintained it was critical to the principles of a fully public service.

The Ministry and the Proponents in 1948

The year 1948, which saw the inception of the NHS and the satisfaction of the medical profession on many major points, also saw the frustration of the proponents on several major issues. These issues included health centres, salaried service, the appointment of health workers' (other than professional) representatives to NHS governing committees, and industrial health, an issue on which the TUC's continued persistence was met by equally continued resistance by the government.

One of Bevan's earliest decisions of 1948, which met at most an ambiguous response from both the TUC and the medical profession, was to curtail formally the much hailed and long promised health centre program. This was announced by the Ministry in January in a circular distributed to the new and not yet functioning health authorities, relieving them of their compulsory responsibility to plan for the implementation of a health centre programme based on new purpose-built centres, and also precluding the conversion of older properties as substitutes on the grounds that the facilities must be the best. The

Ministry cited the need for further investigation into ideal types of centre and the shortage of building materials. Both these reasons are criticised by Eckstein. In the first place, he notes, plenty of planning and experience were available in Britain and abroad. Secondly, the Ministry had already approved the minimal conversion of a number of very substandard properties, and suggested elsewhere in the Circular that further conversions might be considered. Despite the large postwar rebuilding programme, however, the Ministry had taken no initiative even in seeking sites to be reserved for health centres. (27)

The TUC, notwithstanding its early interest in health centres, received Circular 3/48 with equanimity. At its first committee meeting to discuss the policy change, in February 1948, only the MPU representative voiced opposition. By the second meeting in March, the MPU was prepared to support the majority TUC position accepting the Minister's arguments, and decided to press the matter of health centres no further, while continuing to support them in principle. No reasons are recorded in TUC documents for this easy acceptance of such a fundamental change, or for the MPU's change in position. (28)

Even the left Labour journal TRIBUNE, known previously under Bevan's editorship for its determined defence of health centres as the key to reorganising general practice, accepted in good faith the arguments for the curtailment and the promise that at least some experimental centres would be built; only "perfectionists," it now suggested, would criticise the new scheme for the absence of a full system of centres. (29) TRIBUNE continued to note Bevan's progress with organisational aspects of the NHS despite opposition from the medical profession, and to praise his firmness on maintaining the appointed day

and his willingness to make concessions. It mentioned specifically his compromises, on other key Labour Party issues such as a full-time salaried service, pay beds, and private practice, not in criticism of Bevan, but in wonderment that even such major concessions had not placated the BMA. (30)

True to its advocacy of socialist health service principles, the SMA was not entirely happy with Bevan's progress. Not only the BMA was at fault; Bevan in particular had failed despite continuous urging from the SMA to realise the fundamental importance of reorganising general practice in health centres: "The dropping of Health Centres made the Service very much inferior to what it might have been, and has destroyed its attractiveness for thousands of doctors." The SMA again urged Bevan to proceed with the centres, and to include at least the choice of salaried remuneration. (31) While the SMA had raised its concerns formally at the 1947 Labour Party Conference, it did not do so at the 1948 Conference in late May. Instead, the SMA proposed the establishment (which was accepted) of a new Labour Public Health Advisory Committee, to watch over the organisation, implementation and operation of the NHS and to make detailed recommendations through the party. This was to be one of the vehicles through which the issues of health centres and an industrial health service would be pressed on the government.

At the 1948 Conference no debate on the NHS took place; the only direct reference to the service was the comment of a delegate of the Confederation of Health Service Employees (COHSE) urging the government to consider increased worker participation at all levels of the NHS and better working conditions for nurses. Bevan's popularity in the party

was unquestionable; he topped the poll for election to the National Executive Committee. (32)

While the TUC had accepted, at least temporarily, the government's decision to curtail health centre development, it was not willing to take a similar position on an industrial health scheme. From May through the end of 1948 - and after - it pursued several tactics, with its member unions and with three government departments, in order to bring the strongest pressure to bear upon the government. In early 1948 the TUC established a new Social Insurance and Industrial Welfare Committee, with three subcommittees to match branches of the new state programmes: industrial health and welfare, National Insurance, and the NHS. These TUC committees would direct their efforts toward preparation of detailed advice to the government.

In March the Committee made representation on behalf of the TUC to the Minister of National Insurance, urging increased government action in research, prevention and treatment of industrial accidents and diseases, and widened provisions for compensation under the new Industrial Injuries Act for workers suffering employment related disabilities. (33)

Limited Development of the Service, 1948 to 1950

Through 1948 to 1950, developments were slow with the three remaining issues pursued by the advocates: workers' representation, health centres, and an industrial or occupational health service.

The TUC took the lead in pressing the Ministry of Health for formal representation for health workers in NHS administrative bodies, with only very limited success. By October 1948 the Central Health Services

Council had been appointed, and the TUC complained that not one of its nominees had been chosen. Bevan's response was to ask the TUC to submit nominees for the Standing Advisory Committees, under the Central Council. He did not agree with the TUC that there was medical overweighting on the regional hospital boards, and he could not influence the appointment of hospital management committees which were appointed by the regional boards, but he was actively urging the appointment of house committees, which "should be genuinely representative of the communities they were to serve." Nominees were selected by the member unions in December 1948. By February 1949 the nine Standing Committees had been appointed; TUC representatives were appointed one each to only five committees. No trade union nominees (including those put forward by the MPU, nursing unions and COHSE) were appointed to the Medical, Dental, Nursing, or Cancer and Radiotherapy Committees. Between March and June 1949, the TUC reappraised its strategy for attempting to have nominees appointed, acting particularly on the request of a deputation from the National Advisory Council for the Nursing Profession. With respect to appointments to hospital management committees, the TUC decided to urge local trade councils to make nominations, then make a survey of the results. By October 1949 a survey by the Scottish TUC indicated only four per cent of members of regional boards and management committees were drawn from the trade union movement.

From 1949 through to early 1951, the TUC met Bevan several more times to urge greater trade union and public representation; it also encouraged trades councils to submit nominees in 1950 to coincide with the lapsing of two-year terms of the first set of NHS appointees. But

up to the end of Bevan's term as Minister, the TUC remained frustrated in its attempts; at the TUC's final deputation, Bevan was persuaded to allow election of NHS employees only as members of the public, not as representatives, and only to committees not of their own hospitals. He continued to insist that staff associations were the only appropriate avenue of direct representation: they "gave the best opportunity for putting the valuable knowledge and experience of the staffs at the disposal of the hospital management." This then was the end of attempts by the TUC, during Bevan's term, to secure wider democratic representation of health workers. (34)

The Labour Party was the focal point of the advocates' attempts to restore the provision of health centres as an integral part of the NHS, following Bevan's circular of early 1948. Although in the atmosphere of strife surrounding the inception of the NHS the advocates were loath to criticise the government, the SMA published in June its criticisms of the lack of provision of health centres and occupational health services. Clearly under pressure from his supporters on these issues, Bevan in December requested the Central Health Services Council to appoint a special committee on health centres. This committee reported two years later, in December 1950, with both long-term and interim recommendations, emphasising the gradual phasing-in of comprehensive centres, beginning with the immediate encouragement of simple group practices and the building of a few experimentally designed centres. The report also suggested immediate planning for centres in new towns and large estates, despite economic difficulties. In the intervening period, the advocates did not lose sight of health centres. The Labour Party's election policy, "Labour Believes in Britain," drafted in

January 1949 by the health group under Dr Edith Summerskill, promised the building of health centres as necessary for realising the full benefit of the NHS. In March 1949, Bevan opened the first showpiece health centre, Woodberry Down, in the east end of London. In the same month, the MPU delivered a report to Bevan comprising detailed recommendations for health centre development. In November, the 1949 Congress of the TUC passed a resolution, moved by the Association of Building Technicians and seconded by the MPU, asking the government for an immediate commitment to build one hundred health centres, and to complete a full national programme within ten years. Bevan's reply, discussed by the TUC in February 1950, indicated that any substantial provision of centres was out of the question due to the priority of house building. While the TUC took no further action, the SMA was not yet prepared to let the matter drop; it attempted to answer the official reason of building economies with renewed assertions of the urgency of centres to complete the NHS, and suggestions that skillful adaptations of existing buildings -- "make do and mend" -- be undertaken. (35)

Labour won the February 1950 general election with a reduced majority. Against the background of increased pressure for economies (prescription charges had been announced by the Prime Minister in October 1949), including the appointment of a Cabinet committee to oversee NHS spending, much resented by Bevan, and the ceiling imposed on NHS spending in Stafford Cripps' budget, it appeared highly unlikely in 1950 that sufficient funds would be found to complete the promise of a full health centre programme. (36) In this context, and that of the increasing tension between Bevan and his Cabinet colleagues, even the short term recommendations of the Central Health Services Council report

on health centres fell on infertile ground.

A similar course of events with respect to industrial or occupational health services occurred between 1948 and 1951. In this case it was the TUC, both independently and jointly with the co-operation of the BMA and the Labour Party health policy committee, which took the initiative. The TUC made a series of independent approaches to Mr Griffiths, the Minister of National Insurance, in March 1948, and to Mr Isaacs, the Minister of Labour, in May, June and July, to discuss weaknesses in the factory inspectorate to be established under the Factories Bill, to urge a greater government commitment to research into industrial disease and injury, and to request compensation benefits for workers suffering from employment-related diseases whether listed under the Industrial Injuries Act or not. Detailed evidence and recommendations were submitted, along with criticisms of inefficiency in the existing services and government inaction.

In September Bevan announced that the creation of an industrial health service must be deferred indefinitely, for lack of manpower. Not content with this answer from the government, the TUC and the Labour Party Public Health Advisory Committee reactivated their activities on industrial health in November. The TUC met Bevan on 5 November, with a request that he establish the beginnings of an industrial health service in a limited number of locations where facilities could easily and economically be provided. Ministry files do not record Bevan's response. In December the Labour Party-TUC committee published detailed proposals, and the BMA joined with the TUC in the pressure campaign to have a service established.

The BMA had passed a resolution in support of an industrial medical

service in 1945 and was now taking action at the local level, encouraging Joint Councils of medical and trades council representatives to discuss both local and general policy questions concerning industrial health. The TUC was quick to agree that such joint local activity could facilitate a full national service, and agreed to lend support. It also agreed to establish close liaison with the BMA Occupational Health Committee, which was preparing a draft scheme for a comprehensive occupational health service.

The Labour Party and TUC took some time to formulate their joint policy, with some disagreement on the local administrative structure. While the Labour Party committee wished to see the service organised primarily locally, under the Medical Officers of Health, the TUC wanted a service nationally organised, under the Ministry. On the general principles of the service, however, there was complete agreement that it should be preventive in orientation, with a strong research component, that it should be integrated as fully as possible with NHS services, and that there should be extensive powers of workplace supervision and regulation. The joint policy was ready by April 1949, with the Labour Party and the TUC agreeing to disagree on the issue of local administrative structure. The promise of a service "as soon as circumstances permit" was presented in the Labour Party's official policy statement, "Labour Believes in Britain," in early 1949.

In the face of this escalation of activity by the TUC, BMA and Labour Party, the government took two measures in May 1949. The Ministry of Health proposed to the TUC the establishment of some limited services for small factories. The proposal was not, however, calculated to please the TUC, since it suggested making local health authorities

responsible, to which the TUC was strongly opposed. The second measure was an invitation to the TUC from the Prime Minister to nominate members for a Committee of Inquiry on Industrial Health Services (the Dale Committee), which was to investigate the best uses of present medical manpower in existing industrial health services. Two nominees were duly named. The Prime Minister, in announcing in the House of Commons the appointment of the Committee, noted that any substantial development of services would be postponed, pending its report. For the remainder of 1949, amid Bevan's expression of worries about his future as Minister, and the Prime Minister's announcement of NHS prescription charges as an economy measure, the TUC, along with the BMA, prepared detailed evidence for the Dale Committee. The two organisations agreed to maintain pressure on both the Ministries of Labour and Health. The TUC's brief was accordingly presented to the Dale Committee in January 1950. During the following year, the TUC met several times with the Ministry of Labour to encourage expansion of the factory inspectorate and to discuss specific cases of industrial injuries and diseases brought forward by a number of member unions. (37)

The report of the Dale Committee, in February 1951, indicated the general concerns of the proponent groups over the urgency of reforms in industrial health. The Committee argued that services covering the widest spectrum of industrial and occupational health problems would be of benefit to workers' health and security, to productivity and work satisfaction, to good industrial morale, and to the industrial efficiency of the nation as a whole. While the committee recognised that the ideal would be a comprehensive service, it concluded that the very limited medical and nursing manpower available would make this

impossible in the short run, and it could recommend only greater co-ordination among government departments, trade unions, the professions and private industry in a new Standing Advisory Committee, the expansion of training programmes and further surveys and experimental schemes.

It was clear by early 1948, when Bevan was consolidating the NHS Act and regulations for implementation of the service that these major outstanding ambitions of the health service advocates -- key elements of their model of an integrated, preventive service -- were in jeopardy. They were in jeopardy because of a complex of factors ranging from the differential representation of medical versus trade union interests within the Ministry of Health, to the decreasing prominence of that Ministry within the government, coinciding with Bevan's increasing political isolation from his Cabinet colleagues, to the overall economies in government spending imposed by Prime Minister Attlee as a result of the sterling convertibility crisis of 1947 and the later decision in favour of large scale rearmament. It was these economies which lay directly behind the cuts imposed in the housebuilding programme (which were never fully implemented) on local authority construction, and which, presumably, were closely related to the decision in early 1948 to curtail local authority construction of health centres.

At the same time, the government finally negotiated with the TUC a policy of wage restraint, in effect a further consolidation of the tripartite bargain between labour, capital and the state, and a further brake on the independence of labour. This policy was approved by the General Council in April and by the annual Congress in September.

Enforcement of restraints on prices and profits was weak however, and the inflationary effect of the devaluation of 1949 was sufficient to cause the annual Congress of September 1950 to reject the tripartite arrangement overwhelmingly.

Not only the Ministry of Health was in a period of retrenchment between the implementation of the NHS in 1948, without the features central to the advocates' model, and the fall of the Labour government in October 1951. The shift from physical and manpower planning to financial planning between 1947 and 1950 as the basis of Treasury policy for guiding the economy, along with restraints on social spending, caused an irreparable rift in the government, in which Bevan and the Keep Left group of Labour backbenchers opposed the orthodox approach of Chancellors Dalton, Cripps, and finally Gaitskell. (39) As Michael Foot reports, Bevan waged a solitary battle in Cabinet against spending restraints, a battle parallel to that of his Keep Left colleagues but unco-ordinated, due to his devotion to Cabinet secrecy.

Having succeeded in persuading Cripps not to implement a one-shilling charge on NHS prescriptions, the powers for which were included under Treasury pressure in the 1949 NHS (Amendment) Act, Bevan had to accept both a ceiling on NHS spending and the surveillance of the NHS by a special weekly Cabinet Committee, of which Hugh Gaitskell, Bevan's nemesis on the matter of health service charges, was a member. In October 1950 Gaitskell succeeded Cripps as Chancellor, against Bevan's objections, and renewed his demands for charges in the health service. Bevan, locked in the secrecy of the Cabinet, in opposition to the majority view in favour of massive rearmament, agreed in January 1951 to Attlee's suggestion that he take over the Ministry of Labour, on

the condition that the 1950 compromise, to reject NHS charges, be honored.

Bevan was succeeded on 17 January 1951 at the Ministry of Health by Hilary Marquand who was identified with the Gaitskell School of fiscal planning. By March, however, Gaitskell and the Treasury, in concert with Herbert Morrison, had marshalled sufficient support for the imposition of charges, against Bevan's continued opposition, that the Cabinet voted in favour of a fifty percent charge on false teeth and spectacles. This was announced in Gaitskell's budget on 10 April, and an amending Bill introduced in the Commons in late April. Against this majority position, Bevan carried out his threat to resign from the government on 21 April, along with Harold Wilson and John Freeman, at that time making public his opposition to government policy on a number of fiscal and foreign policy issues, including his view that charges were absolutely contrary to the principle of a free health service. (40)

Conclusion

In this climate of fiscal restraint and the emergence of a new orthodoxy in the government in favour of deterrent or use charges, and of Bevan's increasing isolation both from his Cabinet colleagues and his backbench colleagues of the Labour left, proposals for the expansion of the NHS to embrace its original aims, in the case of health centres, or the model of the advocates, in the case of occupational health services, stood little chance.

In the area of workers' representation, even though there was close central consultation between the TUC and the government following the agreement of the TUC to wage restraint, the TUC's entreaties during 1948

for increased formal representation at all levels of the NHS were not met by the government.

While the health service was being consolidated administratively between 1948 and the end of the Labour government in October 1951, and the medical profession had been accommodated in the Amending Act of 1949 preventing imposition of a salaried service, the advocates were repeatedly frustrated in their attempts to extend the service to their original model. They were left little option but to defend the service as it was, against attacks from the right. The SMA, notwithstanding, continued to oppose retrenchment from the original goals of the service, maintaining a campaign against health service charges through 1951. At the TUC Congress of 1951, there was a substantial split on the issue, the General Council's position in support of the government winning only narrowly against opposition to the charges. Bevan himself, and a number of prominent 'Bevanites' did well in elections to the National Executive Council at Labour's 1951 conference.

After the inauguration of the NHS in 1948 and after the conclusion of Bevan's compromise with the medical profession - the Amending Act of 1949 - the chief problematic within the state with respect to the NHS was Bevan's increasingly less successful struggle to defend it from cuts and charges imposed under the new Treasury fiscal policy. Even though the health service advocates were intimately concerned with NHS policy, Bevan's adherence to Cabinet secrecy prevented him from enlisting extra-parliamentary or even backbench support from them or others in defence of original health service principles. In addition, the alliance between the TUC and Labour government leadership would appear to have been a factor in the General Council's reluctance to mount a vigorous

defence of those principles, or even to press the additional issues fundamental to TUC health policy. This left the SMA to carry on its pressure activities in much greater isolation than previously. It might be concluded then that the representation of the advocates in state policy making during the 1948 to 1951 consolidation of the NHS was extremely weak. Indeed even the 'representation' of the NHS, under Bevan's guardianship, within government policy making, was faltering in the face of the Cabinet's turn to the more conservative fiscal policy long advocated by the Treasury and Chancellor Hugh Gaitskell.

By the end of Labour's term of office in October 1951 the stage was set for only the most minimal progress in the following decade, in most cases without central encouragement, in the provision of health centres and industrial health services.

CHAPTER 9 - FOOTNOTES

1. Foot, Vol. II, pp. 116-119. Foot describes in some detail the working relationships developed by Bevan with the leaders of the several professional organisations, pp. 120-126.
2. PRO, MH 77/119, Correspondence: Dr Charles Hill to Bevan, 8 November 1945; Bevan to Hill, 13 November 1945.
3. BMA, Minutes of Negotiating Committee (NC), NC 38, 20 November 1945; NC 47, Minutes of Meeting with Bevan, 4 December 1945; PRO, MH 77/119, NHS (45) 47, Minutes of Meeting of the Negotiating Committee with the Minister, 4 December 1945; BMA, NC 49 and 51, Minutes of Meetings of Compensation Sub-committee 13 and 21 December 1945; PRO, MH 77/119, NHS (45) 48 and NHS (46) 1.
4. Foot, Vol. II, p. 127.
5. PRO, MH 77/119, NHS (46) 3, "Proposals for a National Health Service," and Minutes of Meeting between the Minister and Officials, and the Negotiating Committee, 10 January 1946.
6. BMA, NC 61, Discussion of the Minister's Proposals, 17 January 1946. See also Foot, Vol. II, pp. 139-144, for a discussion of BMA strategy.
7. PRO, MH 77/119, NHS (46) 7, "Questions put to the Minister by the Negotiating Committee and the Minister's Replies," 23 January 1946; BMA, NC 69, "Minister's Answers to Questions Submitted by Negotiating Committee."
8. PRO, MH 77/119, NHS (46) 17, Meeting of the Minister and the Secretary of State for Scotland with the Negotiating Committee, 6 February 1946; BMA, NC 77, Report of the Negotiating Committee's meeting with the Minister, 6 February 1946.
9. BMA, NC 76, "The Minister's Proposals for a National Health Service--The Negotiating Committee's Observations," Report of the Committee to its Constituent Bodies, 8 February 1946.
10. PRO, CAB 129/7, C.P. (46) 86, "National Health Service," Memorandum by Minister of Health, 1 March 1946; and C.P. (46) 89, "NHS in Scotland," Memorandum by the Secretary of State for Scotland, 1 March 1946. CAB 128/5, C.M. 22 (46), Minutes of Cabinet Meeting, 8 March 1946.
11. Foot, Vol. II, p. 147.
12. BMA, NC 81, Report of Meeting between Negotiating Committee and Representatives of the BHA, 7 February 1946.
13. PRO, MH 77/100, NHS (46) 23, Report of Meeting of the Minister

- with BHA representatives, 11 February 1946; Letter from J. P. Wetenhall, Secretary of the BHA, to Bevan, 14 February 1946, and associated correspondence.
14. PRO, MH 77/100, Correspondence: Memorandum from King Edward's Hospital Fund for London, 14 February 1946; Letters from Sir George Aylwen to Bevan, 11 March 1946, and 27 March 1946.
 15. PRO, MH 76 and 77, Correspondence to the Minister from various hospitals, March-June 1946; Letter from King Edward's Hospital Fund to Bevan, 10 April 1946. MH 77/100 and 79, Letters from King Edward's Fund to Bevan, 8 May and 29 May 1946; Reply from Bevan to Sir Edward Peacock, Chairman of the Fund, 10 June 1946.
 16. Foot, Vol. II, p. 150.
 17. PRO, MH 77/119, NHS (46) 30, 31, 32, Minutes of Meetings with the Negotiating Committee 13, 20, and 27 May 1946; BMA, NC 102, 104, 106, Minutes of Meetings with the Minister, 13, 20, and 27 May 1946.
 18. Parliamentary Debates, House of Commons, Standing Committee C, 19th Day's Proceedings, cols. 924 ff.; cols. 525-528; cols. 594-596; BMA, NC 113, Minutes of Meeting to Consider an Analysis of Results of the Committee Stage, 16 July 1946.
 19. PRO, MH 77/119, Letter from Mr H. S. Souttar, BMA President, to Sir Arthur Rucker, Ministry of Health, 5 June 1946.
 20. Foot, Vol. II, p. 156. Foot quotes the Conservative amendment, and discusses Bevan's Parliamentary strategy, pp. 156-160; see also Lindsey, pp. 43-45; and Ross, pp. 90-93.
 21. Ross, pp. 122-123; BMA, NC 136, Report of Meeting with the Minister, 28 February 1947; Foot, Vol. II, p. 165.
 22. BMA, "The Profession and the National Health Service Act, 1946 -- The Negotiating Committee's Case," BMA Council, 7 November 1947; NC 178, Report of Meeting between the Negotiating Committee and the Minister of Health, 2 and 3 December 1947. See also Foot, Vol. II, pp. 166-171, for a vivid account of these meetings; Foot claims Bevan "rejected a second alternative--the offer of an Amending Act designed to secure clearer definition on some of the disputed points. . . . What he did offer were continued 'adjustments within the framework of the Act,'" p. 169. This appears not to be borne out by the Negotiating Committee's minutes.
 23. Lindsey, pp. 60-61; Ross, p. 125.
 24. Foot, Vol. II, pp. 193-203, describes the events of March to April 1948.
 25. Ibid., p. 199.

26. BMA, NC 179, Minister's Written Comments on the Negotiating Committee's Statement (34 pp.) n.d. Bevan here outlined his offers in detail, and notably predicted delays in the development of the health centre plan, due to "building limitations," while continuing to stress the value of an experimental programme. BMA, NC 189, Minutes of Meeting of Negotiating Committee, 20 May 1948.
27. Ministry of Health, "Health Centres," Circular 3/48, 14 January 1948. Eckstein, THE ENGLISH HEALTH SERVICE, pp. 248-252, concludes that there was little evidence available to indicate the Ministry's real reasons for this major policy change.
28. TUC, Joint Social Insurance Committee, Minutes of Meetings, 11 February and 10 March 1948.
29. "Health Centres," TRIBUNE 588, 16 April 1948.
30. "Bevan and the Doctors," TRIBUNE 570, 12 December 1947; "Westminster Commentary," TRIBUNE 579, 13 February 1948.
31. "For the Record," MEDICINE TODAY AND TOMORROW, 6 March 1948.
32. Labour Party, 1948 Conference Report; Foot, Vol. II, p. 233.
33. WHAT THE TUC IS DOING, Spring 1948, p. 37; TUC, Social Insurance and Industrial Welfare Committee (hereafter SIIWC) Minutes, 10 March 1948.
34. TUC, SIC Minutes 3/10 Nov. 1948, letters of 21 Oct. and 2 Nov. 1948 from Bevan to TUC; SIC 10/10 Feb. 1949; 16/12 May 1949; 18/16 June 1949; 2/13 Oct. 1949. Ross, p. 141, describes the constitution of the Standing Advisory Committees. WHAT THE TUC IS DOING, Spring issues 1949, 1950, 1951, describe the TUC's attempts to secure representation.
35. Ross, pp. 146-148; Labour Party, R.D. 245, Jan. 1949, "Labour Believes in Britain," draft; TUC, SIC Minutes 4/10 Nov. 1949, 11/9 Feb. 1950. MEDICAL WORLD, LXX, No. 4, (18 March 1949): 109-115, presented the MPU's detailed health centre proposals. MEDICINE TODAY AND TOMORROW, 7, No. 5, (Spring 1950). WHAT THE TUC IS DOING, Spring 1950.
36. Hugh Dalton, HIGH TIDE AND AFTER, MEMOIRS, 1945-1960 (London: Frederick Muller, 1962), pp. 365-366.
37. TUC, SIC Minutes 7/10 March 1948, 10/10 June 1948; WHAT THE TUC IS DOING, Spring 1948, 1949; Labour Party, R.D. 232, Dec. 1948, "An Industrial Health Service"; TUC SIC Minutes, 3/10 Nov. 1948, 13/13 April 1949, 11 and 12 May 1949, 15 June 1949, 2 July 1949, 9 and 10 Nov. 1949, 14 Dec. 1949, 9 March 1950, 12 April 1950.
38. "Report of a Committee of Inquiry on Industrial Health Services," (Dale Committee) Cmd. 8170 (London:HNSO, Feb. 1951),

paras. 45 to 81.

39. Samuel H. Beer, "British Politics in the Collectivist Age," (New York: Alfred A. Knopf, 1965), pp. 189-208.

40. Foot, Vol. II, Chapter 8.

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D. INTERVIEWS

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Mr Rudolf Klein, Centre for Studies in Social Policy, 3 May 1977.

Dr David Stark Murray, at his home, Richmond, London, 10 March 1977.

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